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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

P.I.A. ASHEVILLE, INC.;
FIRST WASHINGTON GROUP, INC.;
CONSOLIDATED HEALTH SYSTEMS, INC.; and
PSYCHIATRIC INSTITUTES OF AMERICA, INC.,
Petitioners,

v.

STATE OF NORTH CAROLINA, *ex rel.*,
RUFUS L. EDMISTEN, Attorney General,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

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QUESTIONS PRESENTED

1. Whether Congress impliedly repealed the antitrust laws with respect to hospital acquisitions explicitly approved by state regulatory agencies acting pursuant to their authority under the National Health Planning and Resources Development Act.

2. Whether hospital acquisitions receiving approval by a state agency acting pursuant to a clearly articulated state policy are immune from antitrust review under the "state action" doctrine.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
TABLE OF AUTHORITIES	iv
OPINIONS BELOW	2
JURISDICTION	2
STATUTORY PROVISIONS	2
STATEMENT	2
REASONS FOR GRANTING THE WRIT	7
1. Congress Did Not Intend Regulatory Approvals Under The NHPRDA to be Undercut by the Antitrust Laws	9
2. The State Policy Regarding Hospital Acquisitions Entitles Them to Immunity Under the State-Action Doctrine	21
CONCLUSION	26

TABLE OF AUTHORITIES

CASES: Page

California v. FPC, 369 U.S. 482 (1962) 13
California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980) 6, 8, 21, 22, 23
Carnation Co. v. Pacific Westbound Conference, 383 U.S. 213 (1966) 9
City of Lafayette v. Louisiana Power and Light Co., 435 U.S. 389 (1978) 21
Gordon v. New York Stock Exchange, 422 U.S. 659 (1975) 8, 9, 13, 17, 18
Hoover v. Ronwin, 104 S. Ct. 1989 (1984) 21
Huron Valley, Inc. v. City of Pontiac, 666 F.2d 1029 (6th Cir. 1981) 14
National Gerimedical Hospital and Gerontology Center v. Blue Cross, 452 U.S. 378 (1981)....7, 9, 10, 11, 12, 15
New Motor Vehicle Board of California v. Orrin W. Fox Co., 439 U.S. 96 (1978) 9, 23, 24
North Carolina ex. rel. Morrow v. Califano, 445 F. Supp. 532 (E.D.N.C. 1977), *aff'd summarily*, 435 U.S. 962 (1978) 16
Otter Tail Power Co. v. United States, 410 U.S. 366 (1973) 17
Pan American World Airways, Inc. v. United States, 371 U.S. 296 (1963) 25
Parker v. Brown, 317 U.S. 341 (1943) 4, 5, 21
Town of Hallie v. City of Eau Claire, 700 F.2d 376 (7th Cir. 1983), *cert. granted*, 104 S. Ct. 3508 (No. 82-1832, June 11, 1984) 9, 22
United States v. National Association of Securities Dealers, 422 U.S. 694 (1975) 8, 9, 17, 18
United States v. Philadelphia National Bank, 374 U.S. 321 (1963) 9, 13
United States v. Radio Corporation of America, 358 U.S. 334 (1959) 13, 25
United States v. Southern Motor Carriers Rate Conference, Inc., 702 F.2d 532 (5th Cir. 1983), *cert. granted*, 104 S. Ct. 3508 (No. 82-1922, June 11, 1984) 22, 23

TABLE OF AUTHORITIES—Continued

STATUTES AND REGULATIONS: Page

Federal:

National Health Planning and Resources Development Act of 1974 ..... *passim*
42 U.S.C. § 300k *et seq.* 3
42 U.S.C. § 300k-1 10
42 U.S.C. § 300k-2 ..... 10, 11, 12, 20
42 U.S.C. §§ 300k-2(a) (1), (2), (5), (7), (9) .. 20
42 U.S.C. § 300k-2(b) (1) 11, 14
42 U.S.C. § 300k-2(b) (2) 12
42 U.S.C. § 300k-2(b) (3) 12
42 U.S.C. § 300k-3 10
42 U.S.C. § 300l-1 3
42 U.S.C. § 300l-2 10
42 U.S.C. § 300l-2(a) 10
42 U.S.C. §§ 300m-1, 2 10
42 U.S.C. § 300m-2(a) (4) (B) 11
42 U.S.C. § 300m-3(c) 10
42 U.S.C. § 300m-6 16
42 U.S.C. § 300m-6(d) (1) 11
42 U.S.C. § 300n-1 ..... 4, 10, 13
42 U.S.C. § 300n-1(b) (2) (A) 10
42 U.S.C. § 300n-1(c) 11, 20
42 C.F.R. §§ 121.1-124.607 10
15 U.S.C. §§ 1, 2 2
15 U.S.C. § 18 2
28 U.S.C. § 1254(1) 2
45 Fed. Reg. 20026 (1980) 17, 19
45 Fed. Reg. 20028 (1980) 17, 19
45 Fed. Reg. 20031 (1980) 19
42 Fed. Reg. 4002 (1977) 17
42 Fed. Reg. 4008 (1977) 17

TABLE OF AUTHORITIES—Continued

	Page
State:	
North Carolina Health Planning and Resource Development Act of 1978	3, 24
N.C. Gen. Stat. § 131-175(1)	7, 25
N.C. Gen. Stat. § 131-179(d)	25
N.C. Gen. Stat. § 131-181	20
N.C. Gen. Stat. § 131-182	10
N.C. Gen. Stat. § 131-185	5
N.C. Gen. Stat. §§ 75-1, 2	2
MISCELLANEOUS:	
S. Rep. No. 93-1285, 93rd Cong., 1st Sess. (1974)	11, 12
S. Rep. No. 96-96, 96th Cong., 1st Sess. (1979)	12, 14, 16, 20
H.R. Rep. No. 96-420, 96th Cong., 1st Sess. (1979)	12, 14, 16
H.R. Rep. No. 96-190, 96th Cong., 1st Sess. (1979)	14
Areeda, P. and Turner, D., I *Antitrust Law* § 213, at 76-77	24
Davis, *Administrative Law Treatise*, § 3.3, at 153-157 (2d ed. 1978)	18
Page, *Antitrust, Federalism, and the Regulatory Process: A Reconstruction and Critique of the State Action Exemption After Midcal Aluminum*, 61 B.U.L. Rev. 1099 (1981)	22

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Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

PIA Asheville, Inc., First Washington Group, Inc., Consolidated Health Systems, Inc., and Psychiatric Institutes of America, Inc. petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit in this case.[1]

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[1] Petitioner First Washington Group, Inc. is the parent-corporation of Psychiatric Institutes of America, Inc. (PIA). It was also the parent of Consolidated Health Systems, Inc., a named defendant, which went out of business in June 1984. PIA, in turn, is the parent of PIA Equity, Inc., a non-defendant in this case, which is the parent of petitioner PIA Asheville, Inc. For purposes of convenience, we will refer to petitioners collectively as "PIA."

In addition, during the pendency of this lawsuit, First Washington Group, Inc. was purchased by National Psychiatric Hospitals, Inc., which is a wholly owned subsidiary of National Medical Enterprises, Inc.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit, sitting *en banc*, is not yet reported. The opinion is reprinted as Appendix A in the Appendix to this petition. The opinion of the panel of the court of appeals that was vacated by the court of appeals sitting *en banc* is reported at 722 F.2d 59. It is reprinted as Appendix D in the Appendix to this petition. The opinion of the district court is not reported. It is reprinted as Appendix B in the Appendix to this petition.

JURISDICTION

The judgment of the court of appeals sitting *en banc* was entered on July 16, 1984. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS

Relevant provisions of the National Health Planning and Resources Development Act and of the North Carolina Health Planning and Resource Development Act are reprinted as Appendix E in the Appendix to this petition.

STATEMENT

Petitioners seek review of a decision of a divided United States Court of Appeals for the Fourth Circuit, sitting *en banc*, reversing a decision by the United States District Court for the Western District of North Carolina (Jones, J.) that dismissed an antitrust complaint. The complaint charged that the joint ownership of two psychiatric hospitals in Asheville, North Carolina, violated sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2; section 7 of the Clayton Act, 15 U.S.C. § 18; and the North Carolina antitrust laws, N.C. Gen. Stat. §§ 75-1, 2.

In December, 1979, petitioner Psychiatric Institutes of America ("PIA") entered into an agreement with Duke

University to purchase Highland Hospital, a private nonprofit psychiatric hospital in Asheville, North Carolina. Pet. App. 41a. Under the proposed agreement, as ultimately amended, Highland was to be owned 50 percent by PIA and 50 percent by members of the Duke Medical faculty who were on the staff at Highland. Pet. App. 24a. Shortly thereafter, PIA entered into a separate agreement to purchase Appalachian Hall Hospital, a private for-profit psychiatric hospital in Asheville. Pet. App. 41a. The agreements with Duke University and Appalachian Hall were both conditioned upon the ability of PIA to obtain from the North Carolina Department of Human Resources a Certificate of Need (CON) approving the proposed acquisitions. Pet. App. 41a. This condition was included because the North Carolina Health Planning and Resource Development Act of 1978, N.C. Gen. Stat. § 131-175 *et seq.*, which was passed in conformity with the National Health Planning and Resources Development Act of 1974 (NHPRDA), 42 U.S.C. § 300k *et seq.*, required prior review and approval of all changes of ownership of health care facilities.[2]

The Attorney General of North Carolina initiated this antitrust action on February 22, 1980, alleging that petitioners had conspired to eliminate competition and to acquire a monopoly of private psychiatric hospitals in the western part of the State—defined in the complaint as the region under the jurisdiction of the Western North Carolina Health Systems Agency (HSA), a health planning agency established and funded under the NHPRDA, 42 U.S.C. § 300l-1. PIA moved to dismiss on the grounds that the acquisitions were immune from the federal anti-

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[2] In 1981, North Carolina amended its certificate of need law to exclude acquisitions of existing facilities. See An Act to Amend the North Carolina Health Planning and Resource Development Act of 1978, ch. 651, N.C. Sess. Laws of 1981. Section 14 of the amendments made clear that they were not to apply to any CON reviews completed before October 1, 1981.

trust laws because of a plain repugnancy between those laws and the comprehensive federal and state regulatory structure established by the NHPRDA, and because of the "state action" doctrine of *Parker v. Brown*, 317 U.S. 341 (1943).

The district court stayed the proceedings for more than a year, pending final action on the two CON applications. After a public hearing before the local HSA and approval by the State Department of Human Resources, PIA received a CON for Appalachian Hall on November 30, 1980. The CON application for Highland encountered greater opposition, however. The local HSA held a public hearing and two public meetings on this application. Interested parties representing PIA, the physicians, and Duke University presented their evidence and views. Members of the public, as well as state officials, also participated actively. The North Carolina Attorney General's office provided testimony and submitted a written memorandum urging rejection of the proposed acquisition. Among the issues discussed by the Attorney General as well as by PIA and others were the alleged anticompetitive effects that might result from the joint ownership of Highland and Appalachian Hall. J.A. 110-111.[3]

Initially, based on the recommendation of the HSA, the North Carolina Department of Human Resources denied PIA's CON application for Highland. J.A. 111. Subsequently, upon reconsideration and the presentation of further evidence, the Department approved the CON on June 26, 1981. Pet. App. 42a. Specifically relying on the criteria established by Congress in the NHPRDA, 42 U.S.C. § 300n-1, the Department found that the proposed rates were favorable, that the financing arrangement for the acquisition was beneficial and should "assur[e] that minimal financing will be incorporated in any future

[3] "J.A." references are to the Joint Appendix filed in the court of appeals.

rate increases * * *," and that PIA's ownership of two psychiatric hospitals would not adversely affect the rates at either.[4] J.A. 101-03.

Foregoing his right to appeal this CON decision in state court, *see* N.C. Gen. Stat. § 131-185, the North Carolina Attorney General reactivated this antitrust action. After further argument on the implied immunity and state action issues, the district court dismissed the complaint. Pet. App. 23a-37a. The court found that the NHPRDA, together with the conforming CON law enacted by North Carolina, impliedly repealed the federal antitrust laws with respect to acquisitions receiving regulatory approval. Pet. App. 30a-35a. The court also concluded that the North Carolina health planning law expressed "a clear state policy regarding the need for regulatory review—rather than antitrust scrutiny—of hospital acquisitions." Pet App. 36a. Accordingly, it found that the challenged conduct was also immune under the "state action" doctrine of *Parker v. Brown, supra.* Pet. App. 35a-36a.

A panel of the United States Court of Appeals for the Fourth Circuit affirmed the dismissal. Pet. App. 40a-62a. The majority rested its decision entirely on the conclusion that the NHPRDA impliedly repealed the antitrust laws with respect to acquisitions approved by state planning agencies. According to the panel, "the NHPRDA and the certificate of need procedure it establishes are clearly repugnant to the antitrust laws." Pet. App. 50a. It stated that Congress had adopted the NHPRDA because it had "determined that the problems of rising health care costs and uneven distribution of health care services were better remedied by a system of federal and state planning than by unbridled competi-

[4] The decision also found that the proposal furthered other federally prescribed goals such as financial stability and meeting the needs of the community, including "the medically under-served population." J.A. 73, 101-03.

tion." Pet. App. 50a. The court then found that the application of the antitrust laws to transactions approved by state agencies would unduly interfere with the operation of the regulatory system and subject participants in the CON process to conflicting standards. The panel rejected the view that this conclusion should be altered because the NHPRDA did not require the states to review acquisitions of existing health care facilities, reasoning that Congress gave the states the option of conducting such review because it intended that the Act "be implemented to fit individual state and community needs." Pet. App. 51a. North Carolina, in deciding to regulate such acquisitions, was thus furthering Congressional goals.

Respondent then successfully petitioned the court of appeals to rehear the case *en banc*. A divided court then vacated the panel opinion and reversed the district court's decision to dismiss. The court of appeals first held that the acquisition of Highland Hospital was not immune from antitrust challenge under the state action doctrine. Pet. App. 3a-10a. Invoking the two part test set forth in *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980), the court stated that action taken by private parties would enjoy immunity only if (1) the action was taken pursuant to clearly articulated state policy, and (2) this state policy was enforced through ongoing supervision of the private parties' conduct. The Fourth Circuit conceded that the first part of this test had probably been satisfied, because North Carolina had explicitly approved PIA's acquisition when it granted the CON application. Pet. App. 4a. It concluded that the second part was not satisfied, however, because the State did not monitor PIA's conduct after the acquisition. Pet. App. 8a-10a.

Turning to the question of implied immunity, the court found no immunity for hospital acquisitions receiving regulatory approval. Relying in large part on

the heading of one section of the NHPRDA, the court said that "[t]he overriding aim [of the Act] was obviously to buttress competition." Pet. App. 12a. The court also placed repeated emphasis on the fact that Congress had not ordered review of hospital acquisitions, saying: "it follows that Congress cannot have meant certificate of need review to supplant antitrust review * * *." Pet. App. 12a.[5]

Three judges dissented. Pet. App. 22a. Noting that "the only act immune from antitrust scrutiny considered here is the acquisition of the additional hospital facility," Pet. App. 22a, they adhered to the opinion of the panel holding that petitioners were entitled to implied immunity under the NHPRDA.

REASONS FOR GRANTING THE WRIT

This case presents important questions regarding the federal antitrust laws, on the one hand, and federal and state health care programs, on the other. As this Court has recognized, Congress enacted the NHPRDA in 1974 as a comprehensive regulatory system for the delivery of health care, based on the premise that competition is "not a relevant consideration in the health care industry." *National Gerimedical Hospital and Gerontology Center v. Blue Cross*, 452 U.S. 378, 392 (1981) (*National Gerimedical*). The State of North Carolina, for its part, thereafter created a detailed procedure for reviewing health care expenditures (including the acquisition of all hospitals), expressly finding that "the forces of free market competition are largely absent and government regulation is therefore necessary to control the cost, utilization and distribution of health services." N.C. Gen. Stat. § 131-175(1). But the Fourth Circuit, notwithstanding the clear evidence of both federal and state

[5] The Fourth Circuit also stressed that the remedies available under the NHPRDA were not comparable to those available under the antitrust laws. Pet. App. 14a-16a.

policies, has determined to engraft the antitrust laws, with their conflicting aim of enhancing competition, onto this regulatory system. The court has thus, in one fell swoop, set aside federal policy, state policy, and a rational approach to the delivery of effective health care.

At the outset, we think that the Fourth Circuit was simply mistaken in holding that Congress did not intend to exempt these regulatory decisions from antitrust scrutiny. Although the court of appeals announced that "[t]he overriding aim [of the NHPRDA] was obviously to buttress competition," Pet. App. 12a, the fact is that Congress took just the opposite position. The NHPRDA, as its language and legislative history make clear, established an alternative regulatory program precisely because "classic marketplace forces" serve little purpose in the health-care field, especially with regard to inpatient care. See pages 9-15, *infra*. Furthermore, while the court of appeals concluded that Congress could not have intended to displace antitrust challenges without requiring state review of the acquisition at issue, Pet. App. 12a, that view is flatly inconsistent with the Act itself and with the recognition of implied immunity in *Gordon v. New York Stock Exchange*, 422 U.S. 659 (1975), and *United States v. National Association of Securities Dealers*, 422 U.S. 694 (1975), two cases in which Congress authorized but did not compel regulatory action. Equally important, the attempted distinction between authorization and compulsion introduces a needless rigidity into implied-immunity analysis, forcing Congress to an all-or-nothing choice without regard to the needs of individual states. See pages 15-20, *infra*.

We also believe that, quite apart from the intricacies of the NHPRDA, the conduct at issue here was exempt from chalienge under the state-action doctrine. The view of the court of appeals, holding that doctrine inapplicable because the State did not supervise conduct after the acquisition, see *California Retail Liquor Dealers Ass'n v.*

Midcal Aluminum, Inc., 445 U.S. 97 (1980), serves largely to highlight the reasons why the "active supervision" requirement should be abandoned. See *Town of Hallie v. City of Eau Claire*, 700 F.2d 376 (7th Cir. 1983), *cert. granted*, 104 S.Ct. 3508 (No. 82-1832, June 11, 1984) (supervision not required for municipal conduct). Even if the requirement is retained, however, it is illogical to construe it to require continuing supervision of what is essentially a single act. See *New Motor Vehicle Board of California v. Orrin W. Fox Co.*, 439 U.S. 96 (1978). Here, the State of North Carolina clearly expressed its state policy to allow certain types of acquisitions if they were found consistent with state policies regarding health care, and it assured that review of acquisitions would be thorough and intensive. By its odd reading of the *Midcal* test, the Fourth Circuit has effectively overruled that state policy. See pages 21-25, *infra*.

1. Congress Did Not Intend Regulatory Approvals Under The NHPRDA to be Undercut by the Antitrust Laws.

a. It is, of course, a truism that the antitrust laws represent a "fundamental national economic policy." *Carnation Co. v. Pacific Westbound Conference*, 383 U.S. 213, 218 (1966). But this Court has also recognized that Congress may, even without expressly saying so, displace the antitrust laws in favor of a regulatory system. See, e.g., *United States v. National Association of Securities Dealers*, *supra*, 422 U.S. at 719-720; *Gordon v. New York Stock Exchange*, *supra*, 422 U.S. at 682; *United States v. Philadelphia National Bank*, 374 U.S. 321 (1963). "[W]here Congress * * * intend[s] to repeal the antitrust laws, that intent governs." *National Gerimedical*, *supra*, 452 U.S. at 390.

The basic question here, therefore, is whether Congress intended the regulatory process undertaken by North Carolina, pursuant to the provisions of the NHPRDA,

to displace the antitrust laws. Without duplicating the review of the Act in *National Gerimedical, supra*, 452 U.S. at 384-389, it is enough to say that the NHPRDA was intended to establish a cooperative state and federal regulatory system with the goals of eliminating wasteful duplication of health care resources and promoting adequate health care at a reasonable cost. See 42 U.S.C. § 300k-2. To carry out its part of the joint effort, each participating state was required to create a State Health Planning and Development Agency, 42 U.S.C. §§ 300m-1, 2, that was authorized to implement a health planning system consistent with federal standards.[6]

The basic component of this regulatory system is the Certificate of Need (CON) program, which is implemented at the state level pursuant to detailed federal standards and procedures. *See* 42 U.S.C. § 300n-1.[7] Participating states are required to administer CON programs for "the obligation of capital expenditures," "the acquisition of major medical equipment," and "the offer-

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[6] Planning at the local level is accomplished through Health Systems Agencies (HSA). 42 U.S.C. § 300l-2. The HSAs develop health care plans responsive to the needs of their communities. 42 U.S.C. § 300l-2(a). The State Health Planning and Development Agency is responsible for integrating the local plans into a statewide plan and for exercising regulatory control over the planning process. 42 U.S.C. §§ 300m-1, 2. It is advised by a Statewide Health Coordinating Council, composed in part of representatives of local HSAs. 42 U.S.C. § 300m-3(c). Federal coordination of the planning process is achieved in part through a National Council on Health Planning and Development, 42 U.S.C. § 300k-3, and through regulations issued by the Secretary of Health, Education, and Welfare (now Health and Human Services). 42 U.S.C. § 300k-1; see 42 C.F.R. §§ 121.1-124.607 (1981).

[7] The states' Health Planning and Development Agencies are principally responsible for the development and supervision of a CON program. In many states, including North Carolina, see N. C. Gen. Stat. § 131-182, local HSAs conduct the initial review of, and make advisory recommendations on, CON applications. See 42 U.S.C. § 300n-1(b)(2)(A).

ing within the state of new institutional health services." 42 U.S.C. § 300m-2(a)(4)(B). They also must require CON approval for all acquisitions that will result in a change in services or bed capacity of the acquired facility, 42 U.S.C. § 300m-6(d)(1), and, importantly for this case, they may elect to require CONs for all other acquisitions. See pages 16-17, *infra*. The statute identifies fourteen substantive criteria that must be considered by the agency reviewing a CON application, focusing, among other things, on the needs of the relevant community for the services being offered. They specifically require consideration of cost concerns and the role of competition. *See* 42 U.S.C. § 300n-1(c).

The point of singular importance regarding the NHPRDA is that, unlike many statutes under which implied immunity is claimed, Congress enacted it with full attention to the issue of competition. Although the Fourth Circuit said that "[t]he overriding aim was obviously to buttress competition," Pet. App. 12a, no fair reading of the Act could lead to such a conclusion.[8] To the contrary, as this Court recognized in *National Gerimedical, supra*, Congress' decision to enact the NHPRDA was based on a straightforward understanding: that "classic marketplace forces had failed to allocate supply efficiently, contain costs, or ensure the distribution of quality health care." 452 U.S. at 387 n. 10, *quoting* S. Rep. No. 93-1285, 93rd Cong., 1st Sess. 39 (1974) (hereinafter "1974 Senate Report"). More specifically, Congress recognized that the highly technical nature of medical services, the role of the doctor as primary decisionmaker, and the prevalence of health insurance and other third party reimbursement mechanisms, change the usual

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[8] The sole authority cited for that conclusion is the heading of a section containing Congressional findings. See 42 U.S.C. § 300k-2. The section itself, however, contains an express recognition that competition does not appropriately allocate supply with regard to in-patient services. See page 12, *infra*.

influences on consumer behavior, eliminating price as a factor in many health care decisions. *See* 42 U.S.C. § 300k-2(b)(1); 1974 Senate Report, *supra*, at 39; S. Rep. No. 96-96, 96th Cong., 1st Sess. 52-53 (1979) (hereinafter "1979 Senate Report"); H.R. Rep. No. 96-420, 96th Cong., 1st Sess. 57-58 (1979) (hereinafter "1979 House Report").[9] It thus hoped that the CON process would fill the gap left by the failure of the marketplace, helping to restrain prices and prevent needless duplication, and leading to a "more coordinated regionalized system for health services." *See* 1979 Senate Report, *supra*, at 42.

Although Congress later partially modified its view that competition was not "a relevant consideration in the health care industry," *National Gerimedical, supra*, 452 U.S. at 392, it did not do so with regard to in-patient services. Where those services were involved, Congress continued to take the position that "competition does not or will not appropriately allocate supply * * *." 42 U.S.C. § 300k-2(b)(2). It thus directed that, in such areas, state agencies should "take actions (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access and the other purposes of this subchapter) to allocate the supply of such services." *Ibid.*[10]

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[9] Indeed, Congress believed that the ills of the health care industry could be directly traced to the fact that competition did not affect prices as it did in other industries. *See* 42 U.S.C. § 300k-2(b)(1); 1974 Senate Report, *supra*, at 39; 1979 House Report, *supra*, at 57.

[10] It is also noteworthy that even for "health services for which competition appropriately allocates supply consistent with health systems plans," Congress instructed state agencies to give it "priority" only where "appropriate to advance the purposes of quality assurance, cost effectiveness and access." 42 U.S.C. § 300k-2(b)(3).

In light of this unusually pointed legislative history, it is impossible to believe that Congress intended the regulatory system embodied in the NHPRDA to be overridden by a law whose "sole aim * * * is to protect competition." *Gordon v. New York Stock Exchange*, *supra*, 422 U.S. at 689. The very essence of the NHPRDA is not that state agencies should supplement market forces that had proved beneficial but that they should replace forces that had been ineffective or even harmful.[11] While Congress expected that planning agencies would commonly take competition into account, and even required them to do so as part of the CON process, 42 U.S.C. § 300n-1, it gave the possibility of enhanced competition no preeminent role in the regulatory process. That lesser stature is incompatible with the dominant importance of competition under the antitrust laws.

This case amply demonstrates the problems of applying two inconsistent philosophies to the same product. To be-

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[11] In this respect, the regulatory system established by the NHPRDA is very different from the regulatory systems held not to supplant antitrust laws. In *United States v. Philadelphia National Bank*, *supra*, 374 U.S. at 328, involving banking regulation, and *United States v. Radio Corporation of America*, 358 U.S. 334 (1959), involving broadcast regulation, the Court could point to no finding that competition had failed to allocate supply and control prices effectively, and that, therefore, a regulatory agency must assume these functions. Rather, the regulation in those cases was aimed primarily at concerns that are essentially collateral to the antitrust laws, such as protecting "liquidity" and "solvency" in the banking area, 374 U.S. at 352, and coping with the technological limitations on airwaves in the broadcasting industry. *See* 358 U.S. at 349 ("field of broadcasting is one of free competition").

Moreover, in rejecting implied immunity, this Court found that the regulatory agency was either barred from considering all relevant factors relating to competition, *see United States v. Philadelphia National Bank*, *supra*, 374 U.S. at 351; *California v. FPC*, 369 U.S. 482, 486 (1962); *United States v. RCA*, *supra*, 358 U.S. at 343-44, or lacked any statutory guidance about what weight to accord competitive factors. *See United States v. Philadelphia National Bank*, *supra*, 374 U.S. at 351-52. No such prohibition or lack of guidance exists here. See 42 U.S.C. § 300n-1(c).

gin with, it is obvious from the language and tone of the Fourth Circuit opinion that the court believed antitrust scrutiny to be indispensable to the control of prices for in-patient care. See Pet. App. 8a, 16a, 19a (referring to post-acquisition pricing). But Congress has left little doubt that the role of doctors in decisionmaking, coupled with widespread health insurance, makes price competition irrelevant to most medical decisions. See 42 U.S.C. § 300k-2(b)(1); 1979 Senate Report, *supra*, at 52-53; 1979 House Report, *supra*, at 57-58. With regard to in-patient services, in fact, the relevant House Committee concluded in 1979 that the sort of competition favored by the court of appeals could lead to *higher* prices, saying: "[T]he committee believes there is currently little, if any, competition based upon price among institutional health services. For those services *unfettered competition could further aggravate existing health system problems —duplicative and unnecessary services and facilities and rapidly rising costs.*" H.R. Rep. No. 96-190, 96th Cong., 1st Sess. 54 (1979) (emphasis added). Similarly, whereas the court of appeals took the position that the acquisition "in no way helped to ensure that more people had access to the services in question," Pet. App. 14a, the North Carolina Department of Human Resources found that the acquisition did further the goal of meeting the needs of the community, including the "medically underserved population." J.A. 73, 101-103. In short, the Fourth Circuit simply substituted its views for those of Congress and the responsible state agency.[12]

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[12] The Sixth Circuit, unlike the court below, has recognized that such a lack of deference is inappropriate. See *Huron Valley, Inc. v. City of Pontiac*, 666 F.2d 1029 (1981). Although the Sixth Circuit in *Huron Valley* did not decide the implied repeal question, it recognized that, in resolving a claim of immunity, the antitrust court should assess "the extent to which the administrative process must take into account competitive factors and attempt inside the process to reconcile cost containment through regulation with the ideal of efficiency based on competition in the market place." 666 F.2d at 1035.

The attitude of the Fourth Circuit also disserves the regulatory process itself. The granting of a CON for the acquisition of Highland Hospital, far from being a rubberstamp of private conduct, occurred only after numerous public hearings and submissions by interested persons over a period of 18 months. During this period, respondent was free to make (and did make) to an informed regulatory body the very same arguments about competition that he has made in this case, and, even after they were rejected, he was free to make (but did not make) the same arguments in an appeal as provided by state law. Instead, he chose to make what amounts to a collateral attack on the CON decision in federal court. Even if he is ultimately unsuccessful on the merits, the effect will be to demean the regulatory system authorized by Congress and implemented by the State.

The situation in this case is thus very different from the situation in *National Gerimedical, supra*. There, no state agency had approved, or even reviewed, the conduct at issue. Given those peculiar facts, the Court was careful to make its holding a narrow one: that actions taken by private parties—which were neither "compelled nor approved by any governmental regulatory body" but instead constituted "a spontaneous response to the finding of an advisory planning body"—were not immune from antitrust attack. 452 U.S. at 390. At the same time, the Court indicated that " 'there are some activities that must, by implication, be immune from antitrust attack if [state regulatory agencies] are to exercise their authorized powers.' " 452 U.S. at 394 n. 18, quoting Brief for United States as *amicus curiae* at 16 n. 11. This case presents just such circumstances.

b. Although the Fourth Circuit also justified its rejection of implied immunity on the ground that Congress did not *compel* review of hospital acquisitions, Pet. App. 12a, 18a, 19a, its heavy reliance on that factor only

makes matters worse. A standard of implied immunity that turns on compulsory review not only is inconsistent with at least two prior decisions of this Court but creates a needless obstacle to effective regulation.

The regulatory system set up by Congress in the NHPRDA is, quite deliberately, a mixture of affirmative duties, prohibitions, and areas of state discretion. At the first level, of course, participation in the program itself is entirely discretionary for each state. The Act "does not impose a mandatory requirement to enact legislation on the states, it gives to the states an option to enact such legislation * * *." *North Carolina ex. rel. Morrow v. Califano*, 445 F. Supp. 532, 535-36 (E.D.N.C. 1977), *aff'd summarily*, 435 U.S. 962 (1978). Even after a state elects to participate, moreover, Congress gave the states some latitude to adapt programs to their own needs. Thus, for example, Congress required states to conduct CON review of certain activities, said that they "shall not" demand CON approval for other activities, and left some matters, like the acquisition here, to state judgment without direction one way or the other. 42 U.S.C. § 300m-6.

It is clear, however, that Congress expected that individual states would expand their CON programs beyond the minimum federal requirements. The relevant legislative history, emerging from passage of the 1979 Amendments, contains a direct acknowledgment that "State certificate-of-need programs may be more stringent or more comprehensive than the minimum Federal certificate-of-need standards." 1979 Senate Report, *supra*, at 43. The House conference report, in fact, deals specifically with review of acquisitions, saying: "The conferees note that while this provision [42 U.S.C. § 300m] sets forth conditions under which a certificate of need will be required, *it does not preclude a State from* adopting broader coverage requirements or *requiring that all acquisitions be reviewed under normal certificate of*

need procedures." 1979 House Report, *supra*, at 86 (emphasis added). Following this lead, federal regulations promulgated pursuant to the Act expressly affirm state power to regulate all acquisitions if they deem such review appropriate.[13]

Instead of accommodating this discretionary authority, however, the Fourth Circuit used its existence (or, more precisely, the absence of a Congressional directive) to justify application of the antitrust laws. Noting that "the NHPRDA does *not* require state certificate of need programs to review acquisitions entailing no change in bed capacity," Pet. App. 12a (emphasis in original), the court concluded that, as a consequence, "Congress cannot have meant for certificate of need review to supplant antitrust review * * *." *Ibid.* The court went on to emphasize the same point in its loose application of various "tests" for implied immunity, finding it significant that the State had no "duty * * * to enforce an antitrust standard" (Pet. App. 18a) and that the NHPRDA "did not authorize anyone to 'order' anticompetitive conduct." Pet. App. 19a.

This Court, however, has not given, nor should it give, weight to any such distinction. See, e.g., *Gordon v. New York Stock Exchange, supra; United States v. National Association of Securities Dealers, supra; Otter Tail Power Co. v. United States*, 410 U.S. 355 (1973). Indeed,

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[13] The regulations issued before the 1979 Amendments were promulgated at 42 Fed. Reg. 4002, 4008 (1977) and codified at 42 C.F.R. §§ 122.304(a)(2), 123.404(a) (1978). The commentary to the regulations stated that "the question of coverage of acquisitions of existing health care facilities and health maintenance organizations should be left to the States." 42 Fed. Reg. at 4008. After the 1979 Amendments, the Secretary of Health, Education, and Welfare issued proposed regulations implementing the Amendments. 45 Fed. Reg. 20026 (1980). Proposed rule 123.404(a)(5) made clear that "if they choose," states may require certificates of need for all acquisitions "if they believe that acquisitions may be likely to lead to higher health care costs for consumers." 45 Fed. Reg. at 20028.

the opinions in *Gordon* and *National Association of Securities Dealers* make clear by implication that Congressional compulsion is not required. The provision involved in *Gordon*, Section 19(b) of the Exchange Act of 1934, merely "authorized" the Securities and Exchange Commission to alter stock exchange rules if "the Commission determine[d] * * * that such changes are necessary or appropriate for the protection of investors or to insure fair dealing in securities traded upon such exchange * * * ." See 422 U.S. at 666. Even more significantly, the provision at issue in *National Association of Securities Dealers*, Section 22(f) of the Investment Company Act, not only imposed no requirement on the Commission but granted an authority that the Commission had not even exercised. Rejecting the argument that "the SEC's unexercised power to prescribe rules and regulations is insufficient to create repugnancy between its regulatory authority and the antitrust laws," 422 U.S. at 721, the Court found "no way to reconcile the Commission's power to authorize these restrictions with the competing mandate of the antitrust laws." 422 U.S. at 722.

The more rigid approach taken by the Fourth Circuit, by contrast, would frustrate the purposes of having a regulatory scheme in the first place. It is axiomatic that a primary benefit of the administrative process is its flexibility to adapt to varying conditions. See generally Davis, *Administrative Law Treatise*, § 3.3, at 153-157 (2d ed. 1978). That flexibility would be seriously diminished, however, by a requirement that Congress determine in advance what actions administrative agencies shall and shall not take. In addition, of course, regulatory bodies develop a continuing expertise that, in many cases, guides not only the decision about how to resolve particular problems but the equally important decision about what problems to address. Again, if Congress must specify the problems to be reviewed without regard to the different circumstances that may arise, the value of that continuing expertise will often be lost.

These concerns apply with even greater force when the regulatory process is a cooperative one between the federal and state governments. It is inevitable, and often desirable, in our system of federalism that conditions in some states differ from conditions in others. Indeed, the governing regulations in this case recognize that "the effect of competitive forces may vary from location to location." 45 Fed. Reg. 20026, 20031 (1980); see also *id.* at 20028. It is thus entirely consistent with the realities of federal-state cooperation for Congress to allow one state to decide that its policies will be best served by not regulating certain activities and allowing the antitrust laws to control, and to allow another to decide that regulation by a specialized state agency is the best course. It is not consistent with such efforts, however, for a federal court then to insist that, regardless of that choice, the antitrust laws must be applied after all.[14]

An implied exemption from the antitrust laws thus should not depend on whether review of incompatible conduct is required by Congress but simply on whether it is

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[14] Although the Fourth Circuit also emphasized that federal and state planning legislation does not provide for remedies comparable to those available under the Sherman or Clayton Acts, particularly treble damages, Pet. App. 14a-16a, that rationale is equally out of place here. Where Congress intends to *supplant* the antitrust laws with a regulatory system, rather than to shift primary enforcement of antitrust concerns to a regulatory agency, it would be nonsensical for the courts to demand that Congress nonetheless replicate antitrust remedies in the regulatory system. Here, having found that competition is largely irrelevant to the goals of the NHPRDA, Congress obviously had no reason to desire or establish a series of remedies designed to foster competition.

We also note that, under the CON programs established by the NHPRDA and the implementing state legislation, damage remedies, treble or not, would be largely unnecessary. Because the North Carolina statute required that the state planning agencies review every acquisition before it occurred, the denial of a CON would typically stop acquisitions before they had any compensable effects.

consistent with Congressional intent. That test is readily met here. Most important in this regard, perhaps, is the Congressional recognition that "the major responsibility for the implementation of health planning lies with local and state planning agencies." 1979 Senate Report, *supra*, at 55. The Senate Committee, describing the goals of the 1979 Amendments, specifically explained that "[w]e mean a program which keeps most regulatory powers needed to enforce a plan in the hands of State government, not the Federal government * * *." *Id.* at 51. Moreover, in deciding to review all acquisitions, North Carolina has taken action expressly contemplated by Congress (see pages 16-17, *supra*) and directly revelant to the Congressional goal of assuring efficient, less costly care.[15] Its review, in fact, incorporated precisely the standards set out by Congress for areas of mandatory review. Compare 42 U.S.C. § 300n-1(c) with N.C. Gen. Stat. § 131-181.

Contrary to the analysis of the Fourth Circuit, therefore, the voluntary review by North Carolina of acquisitions is no less consistent with the NHPRDA than its review of actions pursuant to Congressional mandate. And the conflict with the antitrust laws is no less great. Under these circumstances, an exemption is necessary for the regulatory system to work as Congress and the State intended.

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[15] For example, the cost of the acquisition, including the manner in which it is financed, is likely to have a direct impact on the rates charged in a cost-based pricing system. In addition, the requirement of regulatory approval can assure that the purchaser is capable of providing effective services to the community, an important goal of the Act. See 42 U.S.C. § 300k-2(a)(1). And acquisitions that result in joint ownership of similar facilities may well further the concern of the NHPRDA to reduce excess supply and ensure the efficient distribution of hospital services. See 42 U.S.C. §§ 300k-2(a)(2), (5), (7), (9).

2. The State Policy Regarding Hospital Acquisitions Entitles Them to Immunity Under the State-Action Doctrine.

We also believe that, even if the NHPRDA did not exist, the acquisition here would be exempt from antitrust challenge under the doctrine of state action. While the Fourth Circuit purported to apply the state-action decisions of this Court, in particular the decision in *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., supra,* it added further uncertainty to an already uncertain doctrine by applying a requirement of continuing supervision to the approval of a non-continuing act. The result is a decision that interferes with state policy yet advances no other legitimate interest.

Although the state-action doctrine has its origins in *Parker v. Brown,* 317 U.S. 341 (1943), the doctrine has not remained static. In holding that no exemption was available here, the Fourth Circuit gave passing mention to *Parker* but relied principally on the test set forth four years ago in *Midcal Aluminum, supra.* Under this test it must be shown, first, that the challenged restraint is "clearly anticipated and affirmatively expressed as state policy" and, second, that the policy is "actively supervised by the state itself." 445 U.S. at 105. See also *City of Lafayette v. Louisiana Power and Light Co.,* 435 U.S. 389, 410 (1978); *Hoover v. Ronwin,* 104 S.Ct. 1989 (1984). While the court of appeals apparently conceded that the first part of the test had been met, it found the second part unsatisfied because "the state makes no attempt to monitor the use of the acquisition." Pet. App. 8a.[16]

The fault with this analysis, to some extent, may lie in the *Midcal* test itself. This Court has already granted

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[16] As the dissenting judges noted, petitioners have claimed an immunity only for the acquisition itself (the action challenged in this suit) not for any subsequent conduct. Pet. App. 22a.

a writ of certiorari to decide whether the "active supervision" requirement should be retained in cases where municipal governments (rather than private parties) are acting pursuant to state policy. See *Town of Hallie v. City of Eau Claire*, 700 F.2d 376 (7th Cir. 1983), *cert. granted*, 104 S.Ct. 3508 (No. 82-1832, June 11, 1984). In that case, the Seventh Circuit held that "[i]f the conduct of local government in providing municipal services is authorized by the state and is clearly articulated and affirmatively expressed as state policy, the activity is state action and entitled to immunity even though state supervision does not exist." *Id.* at 384.

We submit that the "active supervision" requirement should be abandoned, not just for municipal governments, but for private parties as well. See Page, *Antitrust, Federalism, and the Regulatory Process: A Reconstruction and Critique of the State Action Exemption After Midcal Aluminum*, 61 B.U.L. Rev. 1099 (1981). Regardless of whether private or municipal conduct is involved, the two-part standard "undercuts the accepted rationale for the *Parker* doctrine—deference to clearly articulated state regulating policy—by imposing a requirement of command-and-control regulations." *Id.* at 1136-37. While it may be, of course, that either municipal governments or private parties will cause their actions to run counter to the state policy over time, it does not follow that the states need the antitrust laws to protect their own policies. It is far more likely, as this case demonstrates, that the antitrust laws will instead be used to override state policies with which particular litigants or judges disagree.

The debate over the "active supervision" requirement is, at bottom, a debate over the central purpose of the state action exemption. If the purpose is to give immunity only to actions of the State itself or of its veritable proxies, see *United States v. Southern Motor Carriers Rate Conference, Inc.*, 702 F.2d 532 (5th Cir.

1983), *cert. granted*, 104 S.Ct. 3508 (No. 82-1922, June 11, 1984), then the requirement may assure sufficient continuing involvement by the State to justify the immunity.[17] If the purpose, however, is to give states latitude to regulate their own economies, pursuant to clear and strong state policy, the requirement does more to defeat state policies than to advance them. Not only does the requirement allow courts to apply antitrust law in the face of state policies to the contrary (whenever the first but not the second part of the test is met) but the need for state supervision interferes with state choices regarding the administration of its own programs. Under such circumstances, the standard is worse than having no standard at all.

In any event, even if the Court reaffirms *Midcal* in its entirety, it makes no sense to add a gloss, as the Fourth Circuit did, requiring continuing supervision of a one-time event. The presence of ongoing supervision is relevant, if at all, only in situations where state supervision is necessary for the state to ensure that its regulatory goals are satisfied. When, as here, the state policy can be satisfied through one-time regulatory decisionmaking, it actually interferes with that policy for a court to insist that the State do something more. State action does not have to be ongoing to be state action.

This Court appeared to take just such a view in *New Motor Vehicle Board of California v. Orrin W. Fox. Co.*, *supra*. In that case, the Court found that the state action doctrine immunized the California Automobile Franchise Act, which established a scheme of one-time regula-

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[17] The decision in *Southern Motor Carriers Rate Conference* raises the question whether compulsion of a private party is a necessary element of state action immunity. In its opinion, the Fourth Circuit observed that PIA's acquisition was not "compelled" by the State, and that "[t]his argument, too, militates against a finding of state action immunity." Pet. App. 10a.

tory decisionmaking. Under the statute, motor vehicle manufacturers were required to secure the approval of the Motor Vehicle Board before opening a retail auto dealership within the market area of an existing franchise. Although the statute required careful review of the question whether to permit competition within a market area, 439 U.S. at 107-108, it imposed no requirements for subsequent supervision. The statute did not, for example, require rate regulation if the Motor Vehicle Board determined that an existing dealer should not be subjected to competition within its market area; nor, conversely, did the statute contemplate subsequent supervision to ensure that the existing dealer was not injured if the Board permitted the manufacturer to establish a new dealership. 439 U.S. at 100-104. Despite the absence of continuing supervision, the Court held that the "system of regulation" was clearly sufficient to place the scheme outside the reach of the antitrust laws because it implemented a clearly articulated state policy to "displace unfettered business freedom." 439 U.S. at 109.[18]

The North Carolina regulatory system in this case implements the same policy. Like the NHPRDA, the North Carolina Health Planning and Resource Development Act of 1978, N.C. Gen. Stat. § 131-175 *et seq.*, was premised on an express legislative finding "[t]hat because of the manner in which health care is financed, the forces of free market competition are largely absent and that government regulation is therefore necessary to control the cost, utilization, and distribution of health services."

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[18] Commentators have recognized the need to modify the *Midcal* test in such circumstances. Thus, Areeda and Turner have recognized that where a state makes a regulatory decision and, having made that decision, is left with nothing further to do, there is no reason to insist on continuing supervision. See P. Areeda & D. Turner, I *Antitrust Law* § 213, at 76-77. Areeda and Turner would ordinarily require the state to provide a functional substitute for the free market. That requirement is clearly satisfied here.

N.C. Gen. Stat. § 131-175(1).[19] In place of the free market, therefore, the statute established an elaborate process for local and statewide health planning, implemented by a program requiring new or newly acquired health care facilities to obtain a CON from the State Department of Human Resources. See N.C. Gen. Stat. § 131-179(d). As we have noted, the Department approved PIA's application for a CON only after it determined, on the basis of lengthy hearings, that current rates were reasonable, that future rates would not increase unduly, that local needs would be met, that joint ownership would not be harmful, and that a superior alternative "in terms of cost and efficiency has not been shown." J.A. 109-111.

It will do little to advance federal-state relations if state regulatory actions, taken after full consideration and pursuant to state policy, are effectively set aside because the State failed to meet an inapposite, if not impossible, standard. Although the court of appeals obviously believed that the State should review post-acquisition pricing decisions as well as the acquisitions themselves, it is for the State, not the federal courts, to set the boundaries of state policies. The State has approved the acquisition here and that decision should not be subject to judicial second-guessing.

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[19] The fact that the State Attorney General prefers a different system is of no relevance. It is not at all uncommon for even the regulatory agencies themselves to oppose antitrust immunity because of their limited view of their own authority. See, e.g., *Pan American World Airways, Inc. v. United States*, 371 U.S. 296, 298 (1963) (CAB requested U.S. Attorney General to initate antitrust action); *United States v. RCA*, *supra*, 358 U.S. at 350 n.18 (FCC disavowed any authority to foreclose antitrust actions). Nor is it significant that the State later changed its policy regarding review of acquisitions like the one here. See note 2, *supra*. The state action doctrine would be elusive protection indeed if the antitrust laws could be applied retroactively once a particular state policy had changed.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 82-1058

STATE OF NORTH CAROLINA, *ex rel.*,
RUFUS L. EDMISTEN, Attorney General,
Appellant,

—versus—

P.I.A. ASHEVILLE, INC.; FIRST WASHINGTON GROUP, INC.;
CONSOLIDATED HEALTH SYSTEMS, INC.;
PSYCHIATRIC INSTITUTES OF AMERICA, INC.,
Appellees,

UNITED STATES OF AMERICA,
Amicus Curiae.

Appeal from the United States District Court for the
Western District of North Carolina, at Asheville
Woodrow W. Jones, District Judge. (80-29)

ON PETITION FOR REHEARING

Argued: April 3, 1984 Decided: July 16, 1984

WINTER, Chief Judge, RUSSELL, WIDENER, HALL, PHILLIPS, MURNAGHAN, SPROUSE, ERVIN and CHAPMAN, Circuit Judges, sitting *en banc*.

H. A. Cole, Jr., Special Deputy Attorney General (John R. Corne, Associate Attorney General on brief) for Appellant; Andrea Limmer, Department of Justice (William F. Baxter, Assistant Attorney General; John H. Carley, General Counsel; David M. Narrow, Peter M. Kazon, Bureau of Competition, Federal Trade Commission; Barry Grossman, Department of Justice on brief) for Amicus Curiae; Joel I. Klein (Robert D. Luskin, Onek, Klein & Farr; John S. Stevens, Redmond, Stevens, Loftin & Currie; Martin J. Gaynes, Bonner, Thompson, O'Connell, Gaynes & Middlekauff on brief) for Appellees.

RUSSELL, CIRCUIT JUDGE:

A panel of this court initially considered this case in July 1982. The facts were fully stated in the panel opinion, *State of North Carolina ex rel. Edmisten v. P.I.A. Asheville, Inc., et al.*, 722 F.2d 59 (4th Cir. 1983). Given the opportunity to reconsider this case *en banc*, we now reverse the judgment of the district court.

As issue here is the acquisition by Psychiatric Institutes of America (hereafter P.I.A.), the largest national private operator of acute psychiatric hospitals in America, of 50% [1] of the stock of Highland Hospital, a psychiatric facility formerly a division of Duke University Medical Center. P.I.A. also owns and operates the only other private psychiatric hospital in the Western North Carolina Health Systems Agency (hereafter WNCHSA).[2] The National Health Planning and Resources Develop-

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[1] Staff doctors own the other 50%.

[2] A 26 county health service area surrounding Asheville. The WNCHSA is a health systems agency as defined by Title XV of the Public Health Service Act, and the Rules and Regulations implementing that act. *See, N.C. Gen. Stat.* § 131-176(12). It is the WNCHSA which grants certificates of need for all acquisitions in that area.

ment Act of 1974 (NHPRDA), 42 U.S.C. § 300k *et seq.*, required states to pass certificate of need legislation or risk losing federal funds, § 300m-2(a)(4)(B). Under the statute passed by North Carolina, N.C. Gen. Stat. § 131-178(a), P.I.A. had to obtain a certificate of need for the acquisition of Highland, although under the federal statute, a purchase not entailing a change in bed capacity required no certificate.[3] Before the certificate of need was granted, the Attorney General of North Carolina brought this suit challenging the acquisition under federal and state antitrust laws, the Sherman Act, 15 U.S.C. § 1 *et seq.*; the Clayton Act, 15 U.S.C. § 12 *et seq.*; and North Carolina General Statutes §§ 75-1 and 75-2. P.I.A. here contends that since it obtained a certificate of need for the acquisition, and underwent the stringent certificate of need review process mandated by the North Carolina Health Planning Resources Development Act of 1978, N.C. Gen. Stat. § 131-175 *et. seq.*, the acquisition may not now be challenged on antitrust grounds. In the alternative, P.I.A. argues that state action immunity bars the Attorney General's suit. We find that neither the statutes nor state action immunity bars this suit.

I.

We first consider the question of state action immunity, which the panel did not reach. We hold that this doctrine, explained by the Supreme Court in *Parker v. Brown*, 317 U.S. 341 (1943), cannot prevent the acquisition of Highland Hospital from being called into question under the antitrust laws.

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[3] The federal statute requires that certificates of need apply to the "obligation of capital expenditures within the state, and the offering within the state of new institutional health services and the acquisition of major medical equipment," § 300m-2(a)(4)(B), but it also requires that for the acquisition of an existing facility, a certificate of need shall be required *only if* "the services or bed capacity will be changed in being acquired," § 300m-6(d)(1)(B) [emphasis added].

The court in *Parker* held that a state agriculture marketing plan which might otherwise have run afoul of federal antitrust laws was immune from antitrust challenge. The court reasoned that the Sherman Act was not intended to apply to action undertaken by the state in its official capacity. Until recently, it was questionable whether private parties like P.I.A. could claim state action immunity, *see, e.g., Trucking Unlimited v. California Motor Transport Co.*, 432 F.2d 755, 760 n.7 (9th Cir. 1970); *aff'd.* 404 U.S. 508 (1972); *Cantor v. Detroit Edison Co.*, 428 U.S. 579, 590-92 (1976). Of late, the doctrine, still somewhat illogically called state action immunity, *see, Hecht v. Pro Football, Inc.*, 444 F.2d 931, 935 (D.C. Cir. 1971), has been successfully invoked by private parties. Since the Supreme Court's decisions in *Bates v. State Bar of Arizona*, 433 U.S. 350, 362 (1977), and *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980), the right of a private entity to claim *Parker* immunity is clear. Under *Hoover v. Ronwin*, 52 U.S.L.W. 4535 (14 May 1984), a private party has that right even when the state does not compel, but only "authorizes" or "approves" the activity, as North Carolina did here. But under the standard established by those cases, P.I.A. cannot prevail on the merits.

To qualify for state action immunity, a claimant must show two things. One is that there be a "clearly articulated state policy." The second part of the state action immunity two-part test, as set forth in *Midcal*, is that the statutory scheme, here the certificate of need review provision, be subject to *ongoing* state supervision.

The certificate of need requirements represent a "clearly articulated state policy," by the state of North Carolina to regulate even acquisitions of existing health care facilities which result in no change in services or bed capacity. We question whether a clearly articulated policy by the federal government can be found here, *see*

note 3, *supra*, but the state action immunity doctrine, by definition, is restricted to conduct undertaken under the aegis of a state rather than the federal government. Here, since the second part of the test for state action immunity is clearly not met, the first part's being met cannot legitimize P.I.A.'s activity.

The legislative histories of both the NHPRDA of 1974 and of the 1979 amendments thereto, and North Carolina's certificate of need legislation, N.C. Gen. Stat. § 131-175 *et seq.*, do show that Congress and the North Carolina legislature were concerned about the unrelenting rise in the cost of health care, and about wasteful, duplicative major acquisitions by health care providers. The Findings of Fact incorporated in the North Carolina statute at § 131-175 include the statements that:

> (1) . . . the forces of free market competition are largely absent and government regulation is therefore necessary to control the cost, utilization, and distribution of health services. (2) . . . the continuously increasing cost of health care services threatens the health and welfare of the citizens of this state . . . (4) . . . [there has been] costly duplication and underuse of facilities . . .

See, State of North Carolina ex rel. Morrow v. Califano, 445 F. Supp. 532, 534 (E.D.N.C. 1977); *aff'd.*, 435 U.S. 962 (1978); *see also*, S. Rep. No. 93-1285, 93d Cong., 1st Sess. (Nov. 12, 1974), *reprinted in*, 1974 U.S. Code Cong. & Admin News, at 7878; *see also*, 42 U.S.C. § 300k-2(b)(1): ". . . there is duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services."

To control these burgeoning costs, Congress required each state to pass legislation making certificates of need mandatory for major expenditures for health care services, equipment, or facilities. When the Act was amended in 1979, the Senate Report said:

> The legislation recognized State certificate of need programs to be the basic component in an overall effort to control the unnecessary capital expenditures which contribute so greatly to the total national health bill.
>
> The development of new health resources was tied directly to approved state medical facilities plans. Health systems agencies were to be given special funds to encourage development of needed health resources and services in their respective areas.
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> S.Rep. 96-96, 96th Cong., 1st Sess. (April 26, 1979) at 5, *reprinted in* 1979 U.S. Code Cong & Admin. News, vol. 2 at 1310.

North Carolina acted promptly to show its support for the NHPRDA's goals of making better health care more widely available, and of containing costs. In 1978, the North Carolina HPRDA, N.C. Gen. Stat. § 131-175 *et seq.*, was passed.[4] That act required that a certificate of need application be reviewed by the health systems agency of the health service area where the proposed expenditure would be made, § 131-182(a)(1). Thirteen criteria were to be used in deciding whether to grant a certificate of need, § 131-181.[5] These criteria were to be

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[4] N.C. Gen. Stat. §§ 131-175 to 131-188 were repealed by Session Laws 1983, c. 775, s.1, effective Jan. 1, 1984.

[5] (1) The relationship of the proposed project to the State Medical Facilities Plan, the State Health Plan, and the State Mental Health Plan.

(2) The relationship of services reviewed to the long-range development plan of the persons providing or proposing such services.

(3) The need that the population served or to be served by such services has for such services.

(4) The availability of less costly or more effective alternative methods of providing such services.

[Continued]

balanced against the relationship of the proposed expenditure to the state's overall health care goals. Certificates of need could be revoked for failure to satisfy the conditions on which they were granted. North Carolina, then, was sufficiently interested in the regulation of health care provision to legislate extensively in the area. North Carolina's certificate of need program is, we note, even stronger than was mandated by the federal NHPRDA. *Compare*, N.C. Gen. Stat. §§ 131-176(17)b, 131-176(17)(c), and § 131-178, *to* 42 U.S.C. § 300-m6

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[5] [Continued]

(5) The immediate and long-term financial feasibility of the proposal, as well as the probable impact of the proposal on the costs of and charges for providing health services.

(6) The relationship of the services proposed to be provided to the existing health care system of the area in which such services are proposed to be provided.

(7) The availability of resources, including health manpower, management personnel, and funds for capital and operating needs, for the provision of the services proposed to be provided and the availability of alternative uses of such resources for the provision of other health services.

(8) The relationship, including the organizational relationship, of the health services proposed to be provided to ancillary or support services.

(9) Special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas. Such entities may include medical or other health professional schools, multidisciplinary clinics, and specialty centers.

(10) [applicable only to the needs of health maintenance organizations]

(11) [applicable only to the needs of research projects]

(12) [applicable only to construction projects]

(13) The need that the medically underserved portion of the population, especially those people located in rural or economically depressed areas, has for such services, and the extent to which the project under review proposes to meet that need.

(d)(1).[6] Under the circumstances, we acknowledge that there is a strong argument for, and assume, but without deciding that there *was* a clearly articulated and affirmatively expressed state policy to regulate health care providers' expenditures. However, even if North Carolina has regulated such activity as P.I.A.'s, that requirement's being met cannot overcome any failure of the certificate of need requirements to meet the other half of the test—the requirement of continuing state scrutiny.

An examination of the North Carolina certificate of need program shows that after a proposed acquisition passes certificate of need review, the state makes no attempt to monitor the use of the acquisition, *see* N.C. Gen. Stat. §§ 131-175 to 131-187. There is no active supervision at all. No provision, for example, regulates post-acquisition prices. The state does provide for penalties for failure to obtain a certificate of need in situations where one is required, and for failure to incur a financial obligation authorized by a certificate of need. But the statute in no way attempts to monitor the conduct of health care providers to be sure it is in harmony with the expressed goals of the NHPRDA, and with the Findings of Fact in the North Carolina legislation. The mandatory certificate of need requirement constitutes the *sum* of North Carolina's foray into the health services regulation arena established by the NHPRDA. This point is well-illustrated here, where P.I.A. has admitted to raising its prices after it bought Highland Hospital.

The Supreme Court's most recent pronouncement on the state action immunity doctrine reaffirmed the necessity for " 'active supervision' " by the state legislature or state supreme court, *Ronwin*, 52 U.S.L.W. at 4538 (slip op. at 9). The court noted that where the conduct

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[6] The NHPRDA did not require states to require certificate of need review for acquisitions not involving a change in bed capacity. Thus, it cannot be said that Congress has shown any intent at all with respect to the type of acquisition here in question.

being challenged was effectively that of the state itself—either the legislature, or, as was the case in *Ronwin*, the state supreme court—the *Parker* doctrine was inapplicable. But here there can be no contention that P.I.A.'s conduct is in fact that of the state itself. *Ronwin* in no way changes the *Midcal* test for private conduct merely approved by the state, 52 U.S.L.W. at 4538 (slip op. at 9).

P.I.A. has argued that under *New Motor Vehicle Board v. Orrin W. Fox Co.*, 439 U.S. 96, 109 (1978), it meets the test for state action immunity. That decision dealt almost entirely with due process rights to a hearing. In one half-page, however, the court did say that the regulatory scheme there in question is:

> a system of regulation, clearly articulated and affirmatively expressed, designed to displace unfettered business freedom in the matter of the establishment and relocation of automobile dealerships. The regulation is therefore outside the reach of the antitrust laws under the state action exemption.

By that brief statement, the court suggests that the *only* requirement for inferring implied immunity under the state action doctrine is that the statutory scheme express a clearly articulated state policy. The "continuing supervision" requirement for the state action doctrine is not mentioned. However, P.I.A.'s reliance on this case is misplaced. In *Midcal*, decided two years *after New Motor Vehicle Board*, the Supreme Court plainly set out the two-part test for state action immunity which *included* continuing supervision. Although P.I.A. cites *New Motor Vehicle Board* for the proposition that the *absence* of continuing supervision after the acquisition of Highland Hospital need not mean that state action immunity is inappropriate, the argument is unpersuasive. *New Motor Vehicle Board* held state action immunity applicable when *only* the "clearly articulated state policy"

half of the subsequently expressed two-part *Midcal* test was met, so the fact that there was no ongoing supervision was irrelevant to the court's finding, and was not considered.

The total absence of supervision provided by North Carolina after the issuance of a certificate of need is in contrast to the situation in *Bates*, 433 U.S. at 362, and corresponds to the situation in *Midcal*, 445 U.S. at 106. There, the court found that California did not monitor market conditions or "engage in any 'pointed reexamination' of the program," and so found that the second prong of the state action immunity test had not been met. We follow the *Midcal* court, and decline to find P.I.A.'s conduct unreviewable on *Parker v. Brown* grounds.

We also note that the conduct here was voluntarily initiated by P.I.A., and not in any way advocated, much less compelled, by the state. Some state action immunity cases have emphasized that compulsion by the state is a necessary prerequisite to a finding of implied exemption from the antitrust laws, *see, e.g., Goldfarb v. Virginia State Bar*, 421 U.S. 773, 791 (1975). This argument, too, militates against a finding of state action immunity here. Thus P.I.A.'s *Parker v. Brown* argument must fail. For all the foregoing reasons, we find no merit to P.I.A.'s *Parker v. Brown* claim.

II.

We now reach the question whether there is justification in the language of the NHPRDA, or in its legislative history, to find that Congress intended for antitrust immunity to be part of the NHPRDA. We recognize that ". . . . there is no simplistic and mechanically universal doctrine of implied antitrust immunity; each of the Supreme Court's cases is decisively shaped by considerations of the special aspects of the regulated in-

dustry involved," *Phonetele, Inc. v. A.T.&T. Co.*, 664 F.2d 716, 727 (9th Cir. 1981). With this caveat in mind, we will attempt to resolve this question.

There are two principal questions to be answered in deciding when implied repeal of the antitrust laws may be inferred: (1) Is there an affirmative showing of a legislative intent to repeal; and (2) Can the irreconcilability of federal antitrust laws and the regulatory scheme in question be shown,[7] *National Geremedical Hospital and Gerontology Center v. Blue Cross of Kansas City*, 628 F.2d 1050 (8th Cir. 1980); *reversed*, 452 U.S. 378, 382-83 (1981); *see also*, discussion at 628 F.2d 1054; *Essential Communications Systems, Inc. v. A.T.&T.*, 446 F. Supp. 1090, 1094 (D.N.J. 1978).

A.

The "Congressional intent" test for antitrust immunity is broader than the plain repugnancy inquiry, which it embraces. Thus, in trying to determine legislative intent, we look for repugnancy and also consider legislative history, statutory language, and other factors that may suggest what Congress meant, *Oahu Gas Services Inc. v. Pacific Resources, Inc.*, 460 F. Supp. 1359, 1372 (D. Haw. 1978), *Gordon v. New York Stock Exchange*, 422 U.S. 659, 682-83 (1975), *Mount Hood Stages v. Greyhound Corp.*, 555 F.2d 687, 692 (9th Cir. 1977); *cert. denied in part*, 434 U.S. 1008; *vacated and remanded on other grounds*, 437 U.S. 322 (1978); *Phonetele*, 664 F.2d at 726-27.

The language of the NHPRDA itself provides some clues. While the findings of fact in the NHPRDA recognize the shortcomings of competition in improving health services provision, 42 U.S.C. § 300k-(2)(b)(1), the

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[7] *See*, R. Balter and C. Day, "Implied Antitrust Repeals: Principles for Analysis," 86 Dick. L. Rev. 447, 452 (1982).

very section in which these findings appear is entitled "National health priorities; strengthening competition in the supply of services." The overriding aim was obviously to buttress competition; the candid recognition *in that context* of competition's failures is not tantamount to a finding that Congress intended to bar the use of the most powerful pro-competitive laws, the federal antitrust laws, for all NHPRDA-covered activity.

We note again that NHPRDA does *not* require state certificate of need programs to review acquisitions entailing no change in bed capacity. While the statute left states free to pass certificate of need legislation more stringent than was required, of course there can be no claim that Congress intended certificate of need review boards to approve acquisitions like P.I.A.'s of Highland Hospital. If Congress did not intend for certificate of need review boards to approve such acquisitions, it follows that Congress cannot have meant for certificate of need review to supplant antitrust review, although naturally one may argue that the *state's* certificate of need requirement showed a *North Carolina* intent with respect to antitrust review.

We do not find the NHPRDA's legislative history dispositive of the question of Congressional intent.[8] For implied immunity, as for implied rights of action, although:

> The touchstone is now Congressional intent. . . . legislative history is unlikely to reveal affirmative evidence of a Congressional intent to authorize a specific procedure that the statute itself fails to mention, *Middlesex City Sewerage Authority v. Sea Clammers*, 453 U.S. 1, 25 (1981) (Stevens, J., concurring in part and dissenting in part).

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[8] We cannot consider the legislative history of North Carolina's certificate of need program because North Carolina does not publish legislative histories for its statutes.

The legislative history of the 1979 amendments is if anything *less* persuasive of P.I.A.'s position than was that of the 1974 Act, which was totally silent on the subject. The legislative history of the 1979 amendments, after all, shows that they were added in order to provide for competition merely to be *supplemented* by regulation, at least as long as regulation allocates supply in accordance with planning goals, Frances H. Miller, "Antitrust and Certificate of Need: Health Systems Agencies, the Planning Act, and Regulatory Capture," 68 Geo. L.J. 873, 891 (1980); *see also, National Geremedical*, 452 U.S. at 387. The 1974 Act, in contrast, had nothing in its legislative history to indicate what Congress intended the relationship between regulation and competition to be. *See generally, National Geremedical*, 628 F.2d at 1050. And, although *National Geremedical* left open the possibility of antitrust immunity under the NHPRDA, 452 U.S. at 393 n.18, we are entirely unconvinced that the situation here presented is what the Supreme Court contemplated when it refused to "foreclose future claims of antitrust immunity in other factual contexts," *id.* at *id.* The court provided an example of conduct which it might consider covered by implied immunity; P.I.A.'s activity here complained of in no way resembles the example, which suggested that voluntary cooperation between health care providers and health systems agencies might not be considered illegal collusion.

Moreover, there are convincing public policy reasons which militate against a finding of implied immunity here. That the federal antitrust laws are a "fundamental national economic policy," *Carnation Co. v. Pacific Westbound Conference*, 383 U.S. 213, 218 (1966), and have an "indispensable role . . . in the maintenance of a free economy," *United States v. Philadelphia National Bank*, 374 U.S. 321, 348 (1963), no one can seriously dispute.

As one commentator has noted, the goal of the NHPRDA is supposed to be making better health care

more widely available. If this is the aim, however, it is hard to understand why the Sherman Act should not be applied to cases involving regulatory restraints on competition: "Courts have been far too willing to let blatantly anti-competitive conduct slip through the cracks of the Sherman Act by finding that the challenged conduct falls into an antitrust exception," *Note*, "Antitrust and Health Planning under the 1974 NHPRD Act," 7 J. Corp. L. 311, 330 (1982). That article goes on to contend that the "basic flaw" in the certificate of need program is that the restrictions on competition tolerated by the statute do not ensure the availability of the regulated services. Here, the requirement of certificate of need review for an acquistion resulting in no change in bed capacity in no way helped to ensure that more people had access to the health care services in question, so that the justification that certificate of need review replaced antitrust review is not applicable. The article also suggests that the certificate of need program promotes special interests (presumably those of the health care providers who sit on certificate of need review boards). Courts reviewing certificate of need cases have also failed to address the policy question of how much anticompetitive conduct will be, and should be, approved as being in the public's best interest. *Id.* at 330-31.

Many cases have used the availability of remedies as an indicium of whether Congress intended for a regulatory scheme to pre-empt the antitrust laws. Where the regulatory scheme provides for remedies comparable to those available under the Sherman or Clayton Acts, for example, one may infer that the agency was given the power to provide remedies because the antitrust laws were assumed not to be available. If the extent of the remedy available under the regulatory scheme is different from that available under antitrust laws, it is "more probable" that Congress meant the regulatory scheme to act with, and not instead of, the antitrust laws, *Phone-*

tele, 664 F.2d at 735, 735 nn.47, 48. The Civil Aeronautics Board, for instance, has independent power to enforce the antitrust laws, and *Pan American World Airways, Inc. v. U.S.*, 371 U.S. 296, 304 (1963), is one of the very few cases in which the Supreme Court has found implied antitrust immunity. The Federal Communications Commission, on the other hand, has no remedial powers, and assertions of implied immunity based on the alleged pervasiveness of FCC regulations have met with little success. *See, e.g., U.S. v. Radio Corp. of America*, 358 U.S. 334 (1959).

In the area of utilities regulations, the Supreme Court has noted that the Federal Power Commission cannot provide remedial relief for those aggrieved by Clayton Act violations perpetrated in connection with FPC-regulated activity. Since there is no other means of obtaining relief, the court has reasoned, there can have been no Congressional intent to hold the antitrust laws in abeyance with respect to FPC-regulated conduct. Thus the remedies question is important to a finding of Congressional intent, *California v. Federal Power Commission*, 369 U.S. 482, 486 (1962); *Otter Tail Power Co. v. U.S.*, 410 U.S. 366 (1973).

North Carolina's certificate of need law specifies a $20,000 fine to be levied for failure to obtain a certificate of need when one is required, N.C. Gen. Stat. § 131-187(g). If the fine is not paid, a civil suit may be brought by the Department of Human Resources. The statute allows a "person aggrieved" (defined at N.C. Gen. Stat. § 150a-2(6)) to bring suit to enforce the certificate of need law, N.C. Gen. Stat. § 131-188. The Secretary of Human Resources, or any "person aggrieved," may also sue for injunctive relief if a party institutes new health services without obtaining the required certificate of need, N.C. Gen. Stat. § 131-187(i).

These are the only remedies provisions in the North Carolina certificate of need law. None of them resembles

the treble damage provision available for a violation (such as was here alleged) of sections 1 and 2 of the Sherman Act.

Besides not providing remedies for violations of its certificate of need law, North Carolina law seems not to give a remedy for post-acquistion monopolistic conduct. If the acquisition of Highland is held immune from antitrust scrutiny, we think it unlikely that the state will be in a position to sue P.I.A. under federal antitrust laws for raising its rates after the purchase. Certainly the certificate of need review board has no authority to restrain such rate-raising. If it did, that would be some evidence that there is continuing supervision by the regulatory agency. Since it does not, and since it is unlikely that any entity will be able to prevent P.I.A.'s conduct if we hold it immune here, the reasons for our not finding implied immunity are strengthened: "The inference that Congress intended to displace conventional antitrust remedies is certainly stronger if the agency is authorized to award . . . forms of antitrust relief [besides injunctions]. A strict test for implied immunity should therefore include the remedy requirement." *Note*, "A.T.&T. and the Antitrust Laws: A Strict Test for Implied Immunity," 85 Yale L. J. 254, 263 (1975). And, we note that even if the remedies provided by the statutes here were comprehensive or pervasive, which they are not:

> [A] comprehensive remedial scheme can evidence a Congressional decision to preclude other remedies . . . However, we must not lose sight of the fact that our evaluation of a statute's express remedies is merely a tool used to discern Congressional intent; it is not an end in itself. No matter how comprehensive we may consider a statute's remedial scheme to be, Congress is at liberty to leave other remedial avenues open, *Middlesex*, 453 U.S. at 28.

The cases demonstrate that for a finding of implied immunity to be made without clear repugnancy, the regula-

tion in question must be "pervasive," *see, e.g., Ricci v. Chicago Mercantile Exchange*, 409 U.S. 289 (1973). Pervasiveness, in other words, may suffice to show Congressional intent to repeal by implication. As was suggested in *National Geremedical*, 452 U.S. at 392, it may be argued that:

> [T]he fundamental assumption of Congress . . . [in passing the NHPRDA] was that competition was not a relevant consideration in the health care industry. If so, although that industry is not regulated in any comprehensive fashion, it might be concluded that Congress intended 'pervasive' cooperation and planning without the interference of antitrust suits.

The court in *National Geremedical*, however, went on to find no such pervasiveness, and no blanket implied repeal, *id.* at 393. As expressed by one court, "pervasiveness" has three "primary indicia:"

> (1) Legislative history indicating a legislative intent to subordinate antitrust to regulatory policy;
>
> (2) Duty to actively enforce a nondiscretionary antitrust standard of administrative regulation;
>
> (3) The availability of remedial relief under the regulatory scheme commensurate with that of the antitrust law. *Oahu*, 460 F. Supp. at 1374; *see also, California v. FPC*, 369 U.S. at 485; *U.S. v. R.C.A.*, 358 U.S. at 346, 350.

Stated slightly differently by the Ninth Circuit, the three indicia are:

> (1) Explicit Congressional approval of the ultimate anti-competitive effect of the challenged conduct;
>
> (2) Explicit authorization by Congress to an agency or private entity to order the challenged anticompetitive conduct;

(3) No inconsistency between the challenged conduct and an express policy of the governing agency. *Phonetele*, 664 F.2d at 731-32.

The public interest standard under which many regulatory agencies operate *precludes* a finding of pervasiveness, *Otter Tail*, 410 U.S. at 374, and similarly, for industries operating under the "business judgment" standard, "courts must be hesitant to conclude that Congress intended to override the fundamental national policies embodied in the antitrust laws," *id.*, at *id.* Even the the maintenance of a "close surveillance" by an agency does not show pervasiveness, *Philadelphia National Bank*, 374 U.S. at 352.

We find that the North Carolina HPRDA entirely fails to meet the first of the above-cited pervasiveness tests. True, the certificate of need program's legislative history shows an intent to subordinate antitrust concerns to legislative policy, to the extent that competition has been ineffective in the health care field. P.I.A. and the panel decision in this case relied heavily on that legislative history. We, however, note that the NHPRDA's legislative history also shows concern for allowing competition to operate as fully as possible, so that the benefits of competition will be used, while the regulatory scheme takes over only when competition breaks down; *see*, discussion at p. 10 *supra*. Since the object of the antitrust laws is to preserve the benefits of free competition, we can safely say that this legislative history reflects concern for the antitrust laws.

Moreover, the certificate of need system entirely omits the second and third parts of the pervasiveness test cited above. The certificate of need program has no provision for remedial relief approaching that provided by the antitrust laws, nor does it impose a duty on anyone to enforce an antitrust standard.

We are equally unable to find that the scheme here in question passes muster under the Ninth Circuit per-

vasiveness standard. The legislative history of the NHPRDA, while recognizing the shortcomings of competition in the health care market, hardly was explicit in approving monopolies. More clearly still, the North Carolina HPRDA did not authorize anyone to "order" anticompetitive conduct. At most, the statutes allowed the granting of permission (via a certificate of need) to undertake conduct which might ultimately prove anticompetitive. Finally, we perceive a significant inconsistency between the expressed goals of North Carolina's HPRDA and the conduct of P.I.A. in raising its rates after obtaining a monopoly in the WNCHSA area. Hence, we agree with the Supreme Court in *National Geremedical, supra*, and find no pervasiveness in the NHPRDA's regulatory scheme such as would insulate P.I.A.'s conduct.

B.

If (1), the legislative intent part of the implied immunity test, is not dispositive, then only if (2), the clear repugnancy standard, is met can an implied repeal be found. The courts are in agreement on the irreconciliability standard, also expressed as "clear" or "plain" repugnancy, *Philadelphia National Bank*, 374 U.S. at 351, even though their means of expressing the standard may have varied on occasion.[9] Where plain repugnancy does exist, the antitrust laws may be held repealed only to the minimum extent necessary to resolve the repugnancy, *Silver v. New York Stock Exchange*, 373 U.S. 341, 357 (1963); *Georgia v. Pennsylvania Railroad*, 324 U.S. 439 (1945); *United States v. Borden Co.*, 308 U.S. 188, 199 (1939); *quoting*, *Wood v. U.S.*, 41 U.S. (16 Pet.) 342, 362-63 (1842). "The guiding principle [is] reconcilation of the two statutory schemes," *Silver*, 373 U.S. at 357, rather than "to oust completely

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[9] *See, e.g., Oahu*, 460 F.Supp. at 1365; *Borden*, 308 U.S. at 199; *Philadelphia National Bank*, 374 U.S. at 351; *U.S. v. National Association of Securities Dealers*, 422 U.S. 694, 719-20 (1975); *Essential Communications*, 446 F.Supp. at 1094.

the antitrust laws and supplant them" with the regulatory scheme, *Ricci*, 409 U.S. at 300. A line of cases in the Supreme Court has upheld the plain repugnancy standard,[10] and we see no reason to deviate from this line.

The irreconcilability standard is not always clearly defined in the cases. However, the Supreme Court has at least set a minimum standard for irreconcilability: "It is not enough to show that the two statutes [the antitrust and the regulatory] produce differing results when applied to the same factual situation for that no more than states the problem. Rather, 'when two statutes are capable of co-existence, it is the duty of the courts . . . to regard each as effective,'" *Radzanower v. Touche Ross*, 426 U.S. 148, 155 (1976) [citation omitted]. Here, we perceive no such problem. Recipients of certificates of need under North Carolina's HPRDA need only have considered the certificate of need as one step of the process towards a successful acquisition. Review of the proposed acquisition under the standards of the federal antitrust laws could, and should, have been another step undertaken by P.I.A. Instead, P.I.A. chose to act as if receipt of the certificate of need for Highland's acquisition gave it *carte blanche* to ignore other laws with impunity. We cannot find that the reach of the NHPRDA was so broad and powerful.

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[10] We recognize that *National Association of Securities Dealers*, as far as we can tell only the second case in which the Supreme Court ever found implied antitrust immunity, represents something of an aberration from this line, since it found such immunity in the face of a mere potential, rather than an actual, conflict between the regulatory scheme and the antitrust laws. As one court put it, *NASD*'s "rationale is quite puzzling, and the import of the decision is unclear," *Oahu*, 460 F.Supp. at 1373. *See also*, "Norton, "The Antitrust Immunity Doctrine and *U.S. v. National Association of Securities Dealers*: Stepping on *Otter Tail*," 28 Hastings L.J. 387, 389 (1976). (It is significant that *NASD* was decided over a strong 4-person dissent.) More recent cases have confirmed the plain repugnancy test; *see, e.g., Cantor*, 428 U.S. at 597-98 n.37.

In reaching our decision that implied repeal cannot be found here, we note the difference between the certificate of need requirements of the NHPRDA, and the regulatory requirements in other cases where statutes were or were not found to have impliedly repealed the antitrust laws. For example, conduct regulated by the Civil Aeronautics Act of 1938 with its all-pervasive regulation and continuing scrutiny of all phases of the airline industry was at issue in *Pan American, supra.* The Supreme Court held that for the particular conduct in question, there had been implied repeal of the antitrust laws when the act was passed, but nonetheless refused to preclude the possibility of future antitrust prosecution under the act. Just after *Pan Am, Silver,* 373 U.S. at 357, was decided. There the Court enunciated the now well-known standard that:

> Repeal is to be regarded as implied only if necessary to make the [regulatory] act work, and even then only to the minimum extent necessary.

In *Silver, supra,* the Supreme Court found no irreconcilability between the Securities Exchange Act of 1934 and the antitrust laws, and declined to find immunity from Sherman Act suits. Likewise, in *Ricci, supra,* the plaintiff's claim of antitrust immunity implied by the Commodities Exchange Act was rejected,[11] for the reasons that the regulatory scheme had no antitrust standard built in, and was not pervasive. Therefore, the irreconcilability standard was not met.

Philadelphia National Bank, 374 U.S. at 352, underlines the Supreme Court's reluctance to grant antitrust immunity. There, the Comptroller of Currency had approved a bank merger, *after considering* its antitrust effects. The United States nonetheless brought a Clayton Act suit. Rejecting the claim of immunity, the court

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[11] The antitrust action in question had actually been stayed by the Court of Appeals pending certain factual determinations, and the propriety of the stay was reviewed by the Supreme Court.

noted that the Comptroller had not been required to give the anticompetitive effect factor "any particular weight," when he decided whether to approve the merger. By this reasoning, P.I.A.'s argument that the effect on competition was considered when its certificate of need was granted for Highland carries little weight.

After *Philadelphia National Bank*, Congress amended the Bank Merger Act to incorporate the Clayton Act standards of antitrust review. The Supreme Court still refused to pre-empt Clayton Act challenges to bank mergers, *U.S. v. First City National Bank*, 386 U.S. 361 (1967). We find little support for P.I.A.'s position in any of these cases.

Our careful consideration of all aspects of the question presented here inexorably leads us to the conclusion that the facts of this case provide no basis for an action as disfavored, and consequently as unusual, as a finding of implied repeal of the federal antitrust laws. The district court's judgment is *REVERSED* and the case *REMANDED* to the district court for entry of an order consistent with this opinion.

WIDENER, Circuit Judge, dissenting:

I respectfully dissent for the reasons expressed at length in the panel opinion, *North Carolina ex rel. Edmisten v. P.I.A. Asheville, Inc.*, 722 F.2d 59 (4th Cir. 1983), and would not find it necessary to reach the applicability of *Parker v. Brown*, 317 U.S. 341 (1943). I add for emphasis that the only act immune from antitrust scrutiny considered here is the acquisition of the additional hospital facility. 722 F.2d at 68 n. 13. Any activities of the defendants subsequent to the state-approved acquisition which are in violation of the antitrust laws may be challenged as such under the panel opinion.

Judge Hall and Judge Chapman join in this opinion.

APPENDIX B

IN THE DISTRICT COURT OF THE
UNITED STATES FOR THE
WESTERN DISTRICT OF NORTH CAROLINA

ASHEVILLE DIVISION

A-C-80-29

STATE OF NORTH CAROLINA, *ex rel.*,
RUFUS L. EDMINSTEN, Attorney General,
Plaintiff,

v.

P.I.A. ASHEVILLE, INC.; FIRST WASHINGTON GROUP, INC.;
CONSOLIDATED HEALTH SYSTEMS, INC.; and
PSYCHIATRIC INSTITUTES OF AMERICA, INC.,
Defendants.

[Filed Dec. 9, 1981]

MEMORANDUM OF DECISION

The Plaintiff, State of North Carolina, by its Attorney General, brings this action against the Defendants, P.I.A. Asheville, Inc.; First Washington Group, Inc.; Consolidated Health Systems, Inc. and Psychiatric Institutes of America, Inc., alleging that the Defendants, by owning and operating two psychiatric hospitals in Asheville, North Carolina, have engaged in a continuing combination and conspiracy in restraint of interstate trade and commerce in violation of Sections 1 and 2 of the Sherman Act, 15 U.S.C.A. Sections 1 and 2; Section 7 of

the Clayton Act, 15 U.S.C.A. Section 18, and Sections 75-1 and 75-2 of the North Carolina General Statutes.

The Defendant, Psychiatric Institutes of America, Inc., hereinafter "PIA," is a for-profit corporation with headquarters in Washington, D.C. and owns, in whole or in part, and/or operates 16 private psychiatric hospitals. The other Defendants, P.I.A. Asheville, Inc., the First Washington Group, Inc. and Consolidated Health Systems, Inc. are companies directly related to PIA. The first is a wholly-owned subsidiary which owns PIA's current holdings in North Carolina, and the latter two are related parent corporations of PIA.

There is no dispute as to the facts. In January 1980, PIA entered into an agreement to purchase Appalachian Hall Hospital, a private psychiatric hospital located in Asheville, North Carolina. Such sale was subject to PIA obtaining a certificate of need from the North Carolina Department of Human Resources which certificate was granted on November 30, 1980, and PIA now owns and operates the hospital. In December 1979, PIA entered into an agreement with Duke University to purchase Highland Hospital which at that time was a private non-profit psychiatric hospital located in Asheville. Under the proposed agreement, if the sale went through, Highland would be owned 50% by PIA and 50% by a group of physicians who are currently on the staff of the hospital. This sales was likewise conditioned upon obtaining a certificate of need from the North Carolina Department of Human Resources for the operation of the hospital on a for-profit basis. The Department first denied the application for a certificate of need but later upon a reconsideration granted the certificate.

The Attorney General brought this action prior to the approval of the certificate of need by the Department of Human Resources and alleged that if PIA were permitted to purchase Highland Hospital that it would own and control all of the private psychiatric hospitals in a

geographic area defined as the region under the jurisdiction of the Western North Carolina Health Systems Agency and that such occurrence would constitute a monopoly in violation of federal and state antitrust laws. Now that the certificate has been granted and the sale consummated the Attorney General contends that a monopoly has been created in violation of federal and state law. The Western North Carolina Health Systems Agency was established and funded under the National Health Planning and Resources Development Act of 1974, 42 U.S.C.A. Section 300k, et seq., as amended, and is charged with the duty and responsibility for planning and coordinating health care services in the western part of North Carolina. 42 U.S.C.A. Section 300*l*.

The Defendants moved pursuant to Rule 12(c) of the Federal Rules of Civil Procedure for a judgment dismissing the action or ordering it stayed pending the action of the Department of Human Resources on the applications for the certificates of need for the following reasons: (1) that the combined federal and state regulatory structure confers immunity from antitrust liability over the challenged activities; (2) that the Defendants' action are immunized from antitrust liability by the "State action" immunity; (3) that the challenged actions are immunized by the Noerr-Pennington doctrine; (4) that the doctrine of primary jurisdiction requires dismissal or stay of this action pending the determination by the North Carolina Department of Human Resources whether to grant certificates of need to purchase the two hospitals at issue; (5) that Plaintiff's claim under Section 7 of the Clayton Act must be dismissed for failure to allege the requisite connection with interstate commerce; and (6) that the doctrine of pendent jurisdiction requires dismissal or stay of the state claim if the federal claims are stayed or dismissed.

The Court stayed the proceedings pending the final action of the Department of Human Resources on the

applications for certificates of need and later continued the case pending the decision of the Supreme Court of the United States in the case of *National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City*, No. 80-802. That case was decided by the Court on June 15, 1981 and this Court thereupon ordered another hearing in the cause and now enters its findings and conclusions.

The Defendants contend that the combined federal and state regulatory structure established by the National Health Planning and Resources Development Act of 1974, 42 U.S.C.A. Section 300k et seq., and related statutes, and the North Carolina Health Planning and Resources Development Act of 1978, North Carolina General Statutes 131-175 et seq., confers antitrust immunity on the challenged purchases in view of the fact that each purchase can only be effected if authorized by a certificate of need issued by the North Carolina Department of Human Resources, the state agency operating in accordance with state and federal law. They contend that the comprehensive federal legislation calling for joint state and federal regulation of the health care industry clearly was intended to preempt the antitrust laws, and the North Carolina statute enacted in response to the federal legislation exempts the challenged action under the state action doctrine as well.

The Defendants rely upon the body of federal law which recognizes that the antitrust laws are inapplicable in cases where the challenged activities are subject to a comprehensive federal regulatory system whose goals are repugnant to the basic goals of the antitrust laws. See, *e.g.*, *Gordon v. New York Stock Exchange, Inc.*, 422 U.S. 659, 95 S.Ct. 2598, 45 L.Ed.2d 463 (1975). And similarly, the antitrust laws do not apply to conduct that is comprehensively regulated by state regulatory agencies. See, *e.g.*, *Parker v. Brown*, 317 U.S. 341, 63 S.Ct. 307, 87 L.Ed. 315 (1943).

The Plaintiff contends that the state regulatory scheme established under the North Carolina Health Planning and Resource Development Act of 1978, N.C.G.S. 131-175 et seq., is not sufficiently pervasive to confer antitrust immunity to the challenged purchases due to the limitations imposed by Article I, Section 34 of the North Carolina Constitution. It is further contended that the primary jurisdiction doctrine is inapplicable under the facts of this case as a result of the rule set down in the case of *United States v. Radio Corp. of America*, 358 U.S. 334, 79 S.Ct. 457, 3 L.Ed.2d 354 (1959), and that the antitrust immunity under the doctrine of *Parker v. Brown* is inapplicable due to lack of inconsistency between North Carolina's statutory regulatory scheme and the federal antitrust laws.

The Federal Health Planning Act was enacted specifically because Congress determined that the health care industry did not respond to classic competitive forces, and that efficient and effective utilization of health care facilities required an elimination of needless duplication and expansion of services. See, *e.g.*, S.Rep. No. 93-1285, 93d Cong., 1st Sess. (Nov. 12, 1974), reprinted in 1974 U.S. Code, Cong. & Admin. News at 7878. A primary purpose of the Act was to stimulate states to engage in active and detailed health planning and, as a part of that effort, to enact federally sanctioned certificate of need laws to assure that developments concerning new or newly acquired health facilities and equipment are reviewed and approved by the state. See, *e.g.*, *State of North Carolina ex rel. Morrow v. Califano*, 445 F.Supp. 532 (E.D.N.C. 1977), *sum aff'd*, 435 U.S. 962, 98 S.Ct. 1597, 56 L.Ed.2d 54 (1978). Such certificate of need laws are plainly incompatible with the concept of free competition since their specific objective is to restrict entry into the marketplace. See, *e.g.*, *In re Certificate of Need for Aston Park Hospital*, 282 N.C. 542, 193 S.E.2d 729 (1973).

The 1979 amendments to the Health Planning Act specifically called for strengthening competitive forces in the health care industry where possible, while continuing to recognize that for "inpatient health services . . . competition does not or will not appropriately allocate supply . . . ," 42 U.S.C.A. Section 300k-2(b)(2); see 42 U.S.C.A. Section 300k-2(a). The responsibility for taking competitive factors into account, and for balancing these factors against other considerations in the health field, was placed squarely on the "state health planning and development agencies. . ." 42 U.S.C.A. Section 300k-2(b)(2) and (b)(3). In North Carolina, the federally approved "state health planning and development agency" is the State Department of Human Resources. See 42 U.S.C.A. Section 300m.

The North Carolina Health Planning and Resources Development Act of 1978, G.S. 131-175 et seq., was enacted in conformity with the Health Planning Act, see 42 U.S.C.A. Section 300m-6, and includes a certificate of need law. The Act recognizes that "the forces of free market competition are largely absent" in the health care industry, G.S. 131-175(1), and proceeds to set up an elaborate process for coordinated health planning regionally as well as statewide. To implement effective planning, the Act requires that new or newly acquired health care facilities be granted a certificate of need by the State Department of Human Resources before they can operate. As authorized by the Health Planning Act, see 42 U.S.C.A. Section 300m-6(a)(2)(c), the certificate of need provision applies to acquisitions of existing health care facilities in North Carolina. See G.S. 131-179. In reviewing such acquisitions, the State Department of Human Resources is required to consider, among other factors, "the availability of less costly or more effective alternative methods [of service,]" and the "probable impact of the proposal on the costs of and charges for providing health care services." G.S. 131-181(3)(5).

In compliance with the Health Planning Act, see 42 U.S.C.A. Section 300n-1, the state statute establishes procedures for the review and consideration of applications. Initially, a local Health Systems Agency reviews the application, provides for a series of public hearings and the submission of written comments and information from all interested parties. See G.S. 131-182. After consideration by the Health Systems Agency, the State Department of Human Resources reviews the proposal and renders a written decision, accompanied by specific findings, approving (either outright or conditionally) or disapproving the certificate of need application. G.S. 131-182-184. Any party or any "aggrieved person" may seek administrative review pursuant to the provisions of the North Carolina Administrative Procedure Act, G.S. 150A-1 et seq., and thereafter may seek judicial review of the decision by the state courts. G.S. 150A-43 and G.S. 131-185.

The Defendants' application for a certificate of need has been subject to lengthy proceedings before the local Health Systems Agency and the Department of Human Resources. Apparently, there was no problem in connection with the acquisition of Appalachian Hall but considerable opposition developed to the acquisition of Highland Hospital. The local Health Systems Agency held a public hearing and two public meetings concerning Highland's acquisition. Interested parties representing the seller, Duke University, and the buyer, the Defendants, were present and presented their evidence and views. In addition members of the public and interested state officials appeared and were heard. Among the state officials participating in the hearing were representatives from the Attorney General's office, who provided testimony and submitted written memorandum urging rejection of the proposed acquisition. The alleged anticompetitive effect of the acquisition was discussed at the hearing and meetings by the representatives of the Attorney General, the staff of the local Health Systems

and Agency and others. After the hearing and the meetings were over the local Health Systems Agency recommended that the application for a certificate of need be denied. On January 5, 1981, the Department of Human Resources denied the application finding among other things that the potential for beneficial competitive interaction between Highland and Appalachian Hall will be seriously impaired if the acquisition were approved. At the request of the Defendants a public hearing was held upon their motion for reconsideration on April 15 and 16, 1981 by the local Health Systems Agency and the application was approved by the Department of Human Resources on June 26, 1981. See Findings and Final Decision of the Hearing Officer filed with the Court on July 8, 1981. As can be seen from these findings the State Agency examined and considered the competitive effect of the acquisition of the hospital and the impact it would have on the quality and cost of hospital services in the area.

The Attorney General has elected not to appeal the Department's decision or to make any effort to proceed in state court against the acquisition.

The Court is confronted with the question of whether the Congress by the passage of the National Health Planning and Resources Development Act of 1974 which created a comprehensive federal and state system for the regulation and acquisition of health care facilities implied a repeal of the antitrust laws as applied to the acquisition of Highland Hospital as shown by the facts of this case. Justice Powell in *National Gerimedical Hospital v. Blue Cross*, —— U.S. ——, 101 S.Ct. 2415, —— L.Ed.2d —— (1981), reviewed the general principles of the law applicable to such claims and stated:

> . . .The antitrust laws represent a "fundamental national economic policy." *Carnation Co. v. Pacific Westbound Conference*, 383 U.S. 213, 218 (1966); see *Lafayette v. Louisiana Power & Light Co.*, 435

U.S. 389, 398-399 (1978). "Implied antitrust immunity is not favored, and can be justified only by a convincing showing of clear repugnancy between the antitrust laws and the regulatory system." *United States v. National Association of Securities Dealers*, 422 U.S. 694, 719-720 (1975); see *Gordon v. New York Stock Exchange*, 422 U.S. 659, 682 (1975); *United States v. Philadelphia National Bank*, 374 U.S. 321, 350-351 (1963). "Repeal is not to be regarded as implied only if necessary to make the [subsequent law] work, and even then only to the minimum extent necessary. This is the guiding principle to reconciliation of the two statutory schemes." 341, 357 (1963).

To be sure, where Congress did intend to repeal the antitrust laws, that intent governs, *United States v. National Association of Securities Dealers, supra; Gordon v. New York Stock Exchange, supra,* but this intent must be clear. Even when an industry is regulated substantially, this does not necessarily evidence an intent to repeal the antitrust laws with respect to every action taken within the industry. *E.g., Otter Tail Power Co. v. United States*, 410 U.S. 366, 372-375 (1973); *United States v. RCA*, 358 U.S. 334, 346 (1959). Intent to repeal the antitrust laws is much clearer when a regulatory agency has been empowered to authorize or require the type of conduct under antitrust challenge. *E.g., United States v. National Association of Securities Dealers, supra,* at 730-734; *Gordon v. New York Stock Exchange, supra,* at 689-690.

There appears to be a "plain repugnancy" between the dictates of the antitrust laws and the regulatory provisions that govern hospital acquisitions in North Carolina. The certificate of need law enacted by North Carolina was specifically authorized and contemplated by the Congress when it enacted the Health Planning Act. The

state statute sets up a comprehensive system to regulate the allocation and acquisition of health care facilities in North Carolina and the system is based upon the Act of Congress and the explicit finding, by the Congress and the General Assembly, that free market forces are not appropriate for making such determinations. Instead, the North Carolina Department of Human Resources, a state agency, is charged with weighing the full range of health care considerations including, where appropriate, competitive forces. This federally authorized planning system obviously could not work if determinations by the State Department of Human Resources could be reviewed and reversed by a federal district court under the antitrust laws. The appropriate forum for reviewing such determinations is the state court system as provided by the state statute.

The legislative history of the Health Planning Act indicates that Congress intended to preclude antitrust review of activities subject to certificate of need approval when such approval is contemplated by the provisions of the Act. Representative Paul Rogers, a sponsor of the original 1974 Act and the 1979 amendments commented:

> Concern has been expressed that HSA's and health care providers who voluntarily carry out the mandates of the health planning laws (titles XV and XVI of the Public Health Service Act) may be in violation of the antitrust laws.
>
> . . .
>
> Although Public Law 930641 contains no specific exemption from the antitrust laws, an analysis of the activities required of HSA's and providers indicates that Congress sanctioned actions which might otherwise be in violation of our antitrust laws. The intent of Congress was that HSA's and providers who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to

> the antitrust laws. If they were, Public Law 93-641 simply could not be implemented.

Congressional Record—House, No. 18, Part 1, p. H11962-H11963 (Oct. 10, 1978).

The case of *United States v. Hospital Affiliates International, Inc.*, C.A. 80-3072 (E.D. La., September 30, 1980), relied upon by the Plaintiff, is not to the contrary. That case involved a preliminary injunction against a contemplated hospital acquisition in a state where acquisitions are not subject to certificate of need authorization. In such circumstances there is no regulatory interest at stake and thus no possible repugnancy between the regulatory process and the antitrust laws. The recent case of *Bay Medical Center*, C.A. 79-10297 (E.D. Mich., Jan. 13, 1981) is directly in point. That case, like the one at bar, involved a hospital acquisition in a state requiring certificate of need approval for such acquisition. The Court, finding the certificate of need regulatory system to be inconsistent with the federal antitrust laws, ruled that the contemplated hospital acquisition was exempt from antitrust scrutiny. See also *Huron Valley Hospital, Inc. v. City of Pontiac*, 466 F. Supp. 1301 (E.D. Mich. 1979).

The recent decision of the Supreme Court in *National Gerimedical Hospital v. Blue Cross, supra*, points the way to the decision in this cause. That case involved an antitrust challenge to a Blue Cross decision to deny "participating status" for insurance coverage to a hospital. The local Health Systems Agency had found that there was no need for the hospital services in question, but at the time there was no certificate of need law in Missouri and no state regulatory procedure to determine whether the hospital should be constructed. Notwithstanding, the Eighth Circuit held that the decision by Blue Cross was exempt from review under the antitrust laws. It reasoned that the decision was in conformity

with the spirit of the prior determination made by the Health Systems Agency, and that such agency was charged with health planning responsibilities under the National Health Planning Act. In these circumstances the Eighth Circuit Court concluded that the approach of the Health Planning Act was inconsistent with the dictates of the antitrust laws.

The Supreme Court reversed, finding that there was nothing in the Health Planning Act which "requires Blue Cross to take an action that, in essence, sought to enforce the advisory decision of" the local Health Systems Agency. Slip opinion P. 12. In rejecting the claim for immunity, the Court stressed that "the action challenged here was neither compelled nor approved by any governmental, regulatory body." Slip opinion P. 10. The Court then explained that "this fact is crucial, because antitrust repeals are especially disfavored where the antitrust implications of a business decision have not been considered by a governmental entity." *Id.* at 12.

While reversing the decision of the Eighth Circuit Court on the facts of that case, the Supreme Court pointed out that its holding does not foreclose future claims of antitrust immunity in other factual contexts. See Note 18, page 14, Slip opinion. The pertinent part of said note reads as follows:

> Nevertheless, because Congress has remained convinced that competition does not operate effectively in some parts of the health-care industry, e.g., 42 U.S.C. § 300k-2(b), we emphasize that our holding does not foreclose future claims of antitrust immunity in other factual contexts. Although favoring a reversal in this case, the United States as amicus curiae asserts that "there are some activities that must, by implication, be immune from antitrust attack if HSAs and State Agencies are to exercise their authorized powers.

The facts show that the North Carolina Department of Human Resources is specifically required by Congress to consider the competitive impact of the acquisition along with the other factors delineated in the Health Act and that the Department did indeed consider the competitive impact of the acquisition when acting upon the certificate of need. Thus a regulatory body is authorized and empowered and actually did consider the competitive impact of the acquistion and "the antitrust implications of a business decision has been considered by a governmental body as required by *National Gerimedical.* Thus, subsequent antitrust review is needless and inappropriate.

The Plaintiff cites and relies upon *In re Certificate of Need for Aston Park Hospital, supra,* as a basis for arguing that the acquisition should not be exempt from challenge under the federal antitrust laws. *Aston Park* invalidated an earlier state certificate of need law that had not been enacted pursuant to the Health Planning Act. After the decision in *Aston Park,* the North Carolina General Assembly adopted the certificate of need law at issue in this case. The Act cites that its purpose is to comply with the Federal Health Planning Act. G.S. 131-175(s). Since it is the Health Planning Act which expresses the intent of Congress to exempt certificate of need decisions from antitrust review, *Aston Park* can have no bearing on this question. The exemption is a matter of federal law. The state law implications of the decision in *Aston Park,* if any, should have been explored by the Plaintiff in state court.

On the basis of the facts and the law the Court concludes that antitrust immunity is implied and the acquisition of Highland Hospital by the Defendants is immune from the application of the federal antitrust laws.

The acquisition of Highland Hospital by the Plaintiff is also exempt from the antitrust laws under the "state

action" doctrine originally enunciated in *Parker v. Brown, supra.* The Supreme Court has recently made clear that there are "two standards for antitrust immunity under *Parker v. Brown.* First, the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy'; second, the policy must be 'actively supervised' by the state itself." *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97, 100 S.Ct. 937, 943, 63 L.Ed. 233 (1980), quoting *City of Lafayette v. Louisiana Power & Light Co., supra.* In this case both criteria are amply satisfied.

The certificate of need law adopted by North Carolina requires that hospital acquisitions be subject to careful review and ultimate approval. Its purpose is, as the statute sets forth, to assure effective, efficient and affordable health care services with the specific recognition that free market competition will not achieve these goals. G.S. 131-175. Thus the law expresses a clear state policy regarding the need for regulatory review—rather than antitrust scrutiny—of hospital acquisitions.

This policy is also actively supervised by the state. The state statute requires careful public procedures assuring the presentation of conflicting views. It also requires specific findings by the State Department of Human Resources in accordance with specified statutory criteria. Such findings may be reviewed administratively as well as in the state courts. These procedural assurances and requirements satisfy the active supervision requirements of *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., supra.*

In addition to alleging federal antitrust claims, the Plaintiff also challenges the Defendants' acquisition of the hospital under the North Carolina antitrust laws, G.S. 75-1, 2. The sole basis for seeking federal jurisdiction over the state claims is that they are allegedly

pendent to the federal claims. In such circumstances dismissal of the federal claims likewise warrants dismissal of the pendent claims. See, *e.g.*, *United Mine Workers v. Gibbs*, 383 U.S. 715, 726, 86 S.Ct. 1130, 16 L.Ed.2d 218 (1966); *Rosado v. Wyman*, 397 U.S. 397, 90 S.Ct. 1207, 25 L.Ed.2d 442 (1970); *Save Our Samaritan v. Bay Medical Center*, *supra*. In addition there is no reason why the Plaintiff cannot present these state claims to a state court.

The Court in reaching its decision has considered matters outside of the pleadings and it is therefore necessary to treat the Defendants' motion to dismiss as a motion for summary judgment under Rule 56, Federal Rules of Civil Procedure. After a careful consideration of the pleadings, affidavits, briefs and arguments of counsel the Court concludes that there is no genuine dispute as to any material fact and that the Defendants are entitled to a judgment of dismissal as a matter of law. Such judgment dismissing the action will be entered simultaneously herewith.

This the 8TH day of December, 1981.

/s/ Woodrow W. Jones
Chief Judge

IN THE DISTRICT COURT OF THE
UNITED STATES FOR THE
WESTERN DISTRICT OF NORTH CAROLINA
ASHEVILLE DIVISION

A-C-80-29

STATE OF NORTH CAROLINA, *ex rel.*,
RUFUS L. EDMINSTEN, Attorney General,
Plaintiff,

v.

P.I.A. ASHEVILLE, INC.; FIRST WASHINGTON GROUP, INC.;
CONSOLIDATED HEALTH SYSTEMS, INC.; and
PSYCHIATRIC INSTITUTES OF AMERICA, INC.,
Defendants.

[Filed Dec. 9, 1981]

JUDGMENT

THIS MATTER was heard and determined by the Court as will appear in its findings and conclusions set forth in a Memorandum of Decision filed simultaneously herewith.

IT IS THEREFORE ORDERED, ADJUDGED AND DECREED that the action be, and the same is hereby dismissed with prejudice.

This the 8th day of December, 1981.

/s/ Woodrow W. Jones
Chief Judge

APPENDIX C

UNITED COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 82-1058

STATE OF NORTH CAROLINA, *ex rel.*,
RUFUS L. EDMISTEN, Attorney General,
Appellant,

v.

P.I.A. ASHEVILLE, INC.; FIRST WASHINGTON GROUP, INC.;
CONSOLIDATED HEALTH SYSTEMS, INC.;
PSYCHIATRIC INSTITUTES OF AMERICA, INC.,
Appellees.

UNITED STATES OF AMERICA,
Amicus Curiae.

Appeal from the United States District Court for the
Western District of North Carolina

JUDGMENT

[Filed July 16, 1984]

This cause came on to be heard on the record from the United States District Court for the Western District of North Carolina, and was argued by counsel.

On consideration whereof, It is now here ordered and adjudged by this Court that the judgment of the said District Court appealed from, in this cause, be, and the same is hereby, reversed. The case is remanded to the United States District Court for the Western District of North Carolina, at Asheville for further proceedings consistent with the opinion filed herewith.

/s/ John M. Greacen
Clerk

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 82-1058

STATE OF NORTH CAROLINA, *ex rel.*,
RUFUS L. EDMISTEN, Attorney General,
Appellants

v.

P.I.A. ASHEVILLE, INC.; FIRST WASHINGTON GROUP, INC.;
CONSOLIDATED HEALTH SYSTEMS, INC.; and
PSYCHIATRIC INSTITUTES OF AMERICA, INC.,
Appellees

UNITED STATES OF AMERICA,
Amicus Curiae.

Appeal from the United States District Court for the Western District of North Carolina, at Asheville
Woodrow W. Jones, District Judge. C/A 80-29

Argued July 20, 1982 Decided November 30, 1983

Before RUSSELL, WIDENER and HALL, Circuit Judges.

John R. Corne, Associate Attorney General (H. A. Cole, Jr., Special Deputy Attorney General, on brief) for Ap-

pellants; Joel I. Klein (Robert D. Luskin, Onek, Klein & Farr; John S. Stevens, Redmond, Stevens, Loftin & Currie; Martin J. Gaynes, Bonner, Thompson, O'Connell, Gaynes and Middlekauff, on brief) for Appellees; Andrew Limmer, Department of Justice (John H. Carley, General Counsel, David M. Narrow, Peter M. Kazon, Bureau of Competition, Federal Trade Commission; William F. Baxter, Assistant Attorney General; Barry Grossman, Department of Justice, on brief) for Amicus Curiae.

WIDENER, Circuit Judge:

This case arises out of the acquisition by Psychiatric Institutes of America, Inc. (PIA) of Highland Hospital, a private psychiatric hospital located in Asheville, North Carolina. The Attorney General of North Carolina brought this action against PIA and three related corporations, P.I.A. Asheville, Inc.; First Washington Group, Inc.; and Consolidated Health Systems, Inc., alleging that the defendants' ownership and operation of Highland Hospital and another Asheville psychiatric hospital constitutes a violation of federal and state antitrust laws. This is an appeal by the State from the district court's grant of summary judgment for the defendants on the ground that the acquisition of Highland Hospital was exempt from the antitrust laws.

I.

The facts are undisputed. In December 1979, PIA entered into an agreement to purchase Highland Hospital from Duke University. Subsequently, in January 1980, PIA entered into an agreement to purchase Appalachian Hall Hospital, another psychiatric hospital located in Asheville. Each agreement was conditioned upon PIA obtaining a certificate of need from the North Carolina Department of Human Resources. The certificate of need for the acquisition of Appalachian Hall Hospital was granted on November 30, 1980. On the recommendation of the Western North Carolina Health

Systems Agency, the certificate of need for the acquisition of Highland Hospital was initially denied. Upon reconsideration, however, the certificate of need was granted on June 26, 1981.

The Attorney General brought this action on February 22, 1980, alleging that PIA's acquisition of Highland Hospital, if consummated, would result in its ownership of all the private psychiatric hospitals within the area served by the Western North Carolina Health Systems Agency. He contended that this ownership would constitute a monopoly in violation of sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2, section 7 of the Clayton Act, 15 U.S.C. § 18, and sections 75-1 and 75-2 of the North Carolina General Statutes. The district court stayed the proceedings pending the outcome of the certificate of need applications.

After PIA received the certificates of need, the Attorney General proceeded with his antitrust action, and the district court granted summary judgment for the defendants. The court held that antitrust immunity is implied in the regulatory structure established by the National Health Planning and Resources Development Act of 1974 (NHPRDA), 42 U.S.C. §§ 300k *et seq.* *See, e.g., Gordon v. New York Stock Exchange*, 422 U.S. 659 (1975). It also held in the alternative that the state action doctrine immunizes the defendants from antitrust liability. *See, e.g., Parker v. Brown*, 317 U.S. 341 (1943). The issue presented on appeal is whether the district court properly applied either of these theories of antitrust immunity. We hold that antitrust immunity for the acquisition of Highland Hospital is implied in the regulatory structure of the NHPRDA, and do not reach the question of whether the state action doctrine also grants immunity.

II.

A determination of the applicability of implied antitrust immunity must begin with an examination of the

federal and state regulatory system established by the National Health Planning and Resources Development Act of 1974. Congress enacted the NHPRDA to remedy the problems of rising health care costs and uneven distribution of health care services. 42 U.S.C. § 300k; S. Rep. No. 1285, 93d Cong., 2d Sess. ——, *reprinted in* 1974 U.S. Code Cong. & Ad. News 7842, esp. 7878-79 (hereinafter cited as S.Rep. No. 93-1285).[1] Congress found that the health care industry is unresponsive to classic marketplace forces because physicians commonly make purchasing decisions for their patients and the costs generally are reimbursed by a third party, such as medicare, medicaid, or insurance. S.Rep. No. 93-1285, *supra*, at ——, 1974 U.S. Code Cong. & Ad. News at 7878. Through the NHPRDA, Congress sought to establish a coordinated federal and state regulatory structure to promote health care planning and thereby provide broader access to health care services at a lower cost to consumers. *Id.*

To implement the planning process, the Act created a system of state and local planning agencies. Planning at the local level is accomplished through Health Systems Agencies (HSA's). 42 U.S.C. § 300*l*-2. They must create and implement health care plans responsive to the needs of the community they serve. *Id.* § 300*l*-2(a). A state health planning and development agency is responsible for integrating the local plans into a statewide plan and for exercising regulatory power over the planning process. *Id.* §§ 300m to 300m-2. Ultimate federal control and coordination of the planning process is achieved

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[1] Space does not permit us to abstract the very informative and comprehensive Senate Report here. Its essence follows (from the Report p. 7879): "In the Committee's view, effective comprehensive health planning activities are an absolute prerequisite to the implementation of a national health insurance program which will result in the provision of high quality personal health services to all Americans at reasonable costs."

through a National Council on Health Planning and Development, *id.* § 300k-3, and through regulations issued by the Secretary of Health, Education, and Welfare, *id.* § 300k-1; *see* 42 C.F.R. §§ 121.1-124.607 (1981).

As originally enacted, the NHPRDA listed as HSA planning goals the general improvement of health, increasing the accessibility of health care services, restraining increases in health care costs, and preventing unnecessary duplication of health care resources. 42 U.S.C. § 300*l*-2(a)(1) to (4).[2] In 1979, as part of the Health Planning and Resources Development Amendments, Pub. L. No. 96-79, 93 Stat. 592, Congress amended the NHPRDA to require planning bodies to consider the role of competition in the allocation of health care services.[3] *See id.* § 103, 93 Stat. at 594-95 (codified at 42 U.S.C. §§ 300k-2(a), (b), 300*l*-2(a), 300n-1(c)); S. Rep. No. 96, 96th Cong., 1st Sess. 3, *reprinted in* 1979 U.S. Code Cong. Ad. News 1306, 1308 (hereinafter cited as S. Rep. No. 96-96). In particular, Congress added to the existing purposes of HSA planning the goal of "preserving and improving . . . competition in the health service area." Pub. L. No. 96-79, § 103(c), 93 Stat. at 595 (codified at 42 U.S.C. § 300*l*-2(a)(5)).[4]

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[2] These goals of HSA planning are consistent with the more particularized national health priorities enumerated in the Act. *See* 42 U.S.C. § 300k-2(a).

[3] For a general description of the other changes effected by the 1979 amendments, see S. Rep. No. 96, 96th Cong., 1st Sess. 2-3, *reprinted in* 1979 U.S. Code Cong. & Ad. News 1306, 1307-08.

[4] The amendments also added as a new national health priority, *see supra* note 2, "[t]he strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve . . . to advance the purposes of quality assurance, cost effectiveness, and access." Pub. L. No. 96-79, § 103(a), 93 Stat. 592, 594-95 (1979) (codified at 42 U.S.C. § 300k-2(a)(17)).

In enacting the 1979 amendments, however, Congress restated its view that market forces generally have little effect on restraining health care costs or efficiently allocating health care services. S. Rep. No. 96-96, *supra*, at 52-53, 1979 U.S. Code Cong. & Ad. News at 1357-58; House Comm. on Interstate and Foreign Commerce, *Health Planning and Resources Development Amendments of 1979*, H.R. Rep. No. 190, 96th Cong. 1st Sess. 51-52 (1979) (hereinafter cited as H.R. Rep. No. 96-190); *see* 42 U.S.C. § 300k-2(b)(1). Accordingly, the amendments instructed state planning agencies to promote competition in only those health service areas in which competition allocates supply in accordance with state health care plans. 42 U.S.C. § 300k-2(b)(3). However, "[f]or health services, such as inpatient health services and other institutional health services, for which competition does not appropriately allocate supply," the agencies are to "allocate the supply" rather than leave allocation to market forces. *Id.* § 300k-2(b)(2).[5]

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[5] The full text of § 300k-2(b) reads as follows:

(b)(1) The Congress finds that the effect of competition on decisions of providers respecting the supply of health services and facilities is diminished. The primary source of the lessening of such effect is the prevailing methods of paying for health services by public and private health insurers, particlularly for inpatient health services and other institutional health services. As a result, there is duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services.

(2) For health services, such as inpatient health services and other institutional health services, for which competition does not or will not appropriately allocate supply consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the exercise of their functions under this subchapter take actions (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access and the other purposes of this subchapter) to allocate the supply of such services.

(3) For the health services for which competition appropriately allocates supply consistent with health systems plans and State

As a part of the planning process, each State must administer a certificate of need program. *Id.* § 300m-2 (a) (4) (B). Such a program generally provides for the review of and determination of need for capital expenditures, offerings of new institutional health services, and acquisitions or major medical equipment. *Id.* § 300m-6 (a). The North Carolina certificate of need law, under which the acquistion of Highland Hospital was reviewed, was, in terms, enacted pursuant to the NHPRDA. *See* N. C. Gen. Stat. § 131-175(5) (1981).[6]

In compliance with the procedures mandated by the NHPRDA, *see* 42 U.S.C. § 300n-1, the North Carolina statute provides for initial review of certificate of need applications by the local HSA, N.C. Gen. Stat. 131-182, which in this case was the Western North Carolina Health Systems Agency. The HSA must hold public hearings and allow the submission by interested parties of written comments and other relevant information. *Id.* The HSA's recommendation is reviewed by the State Department of Human Resources, which renders, along with specific findings of fact, an opinion approving or disapproving the CON application. *Id.* §§ 131-182 to -184. Finally, an aggrieved party may seek administra-

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health plans, health systems agencies and State health planning and development agencies should in the performance of their functions under this subchapter give priority (where appropriate to advance the purposes of quality assurance, cost effectiveness and access) to actions which would strengthen the effect of competition on the supply of such services.

[6] In 1981, the North Carolina General Assembly substantially amended the certificate of need law. N.C. Gen. Stat. §§ 131-175 to -187 (Supp. 1981). The amendments, however, do not apply to this case. Any references to the North Carolina certificate of need law will be to the pre-amendment statute unless otherwise indicated. The 1981 amendments abolish the requirement of a certificate of need for the purchase of an existing hospital in the circumstances presented here.

tive and judicial review of the CON determination. *Id.* § 131-185.[7]

III.

The NHPRDA provides no express antitrust immunity for PIA's acquistion of Highland Hospital.[8] PIA claims, however, that implied immunity is clear from both the

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[7] The Attorney General, assuming he has standing under the state statute, has elected not to seek review within the state system of the adverse administrative determination.

[8] The NHPRDA does give HSA's, and the members and employees of HSA's and Statewide Health Coordinating Councils limited immunity from damages under any federal or state law. 42 U.S.C. §§ 300*l*-1(b)(4), 300m-3(d). The United States as amicus curiae argues that these provisions indicate the full extent of Congressional intent to grant antitrust immunity and therefore foreclose any finding of implied antitrust immunity. We find this argument unpersuasive.

These provisions resemble the general grants of limited immunity given to employees under other federal programs for acts done within the scope of their employment. *See, e.g.*, 40 U.S.C. § 489 (granting good faith immunity to federal officers and employees involved in the transfer and disposal of government property); 42 U.S.C. § 300j-6(a) (granting immunity to federal officers, agents, and employees involved in the federal water systems safety program). The fact that Congress has granted health systems agencies and their members limited immunity under the statute for the performance of their duties, we think, is no indication that no further immunity may be implied to others not mentioned and not a part of a health system agency.

In addition, such a holding, that would foreclose all claims of implied antitrust immunity, would run counter to the Supreme Court's language in *National Gerimedical Hospital & Gerontology Center v. Blue Cross*, 452 U.S. 378 (1981). There, the Court recognized the validity of antitrust immunity claims under the NHPRDA in the proper factual context, citing the United State's statement as amicus curiae that " 'there are some activities that must, by implication, be immune from antitrust attack if HSA's and State Agencies are to exercise their authorized powers." *Id.* at 393 n.18 (quoting the Brief for the United States as Amicus Curiae at 16 n.11).

NHPRDA's regulatory structure and its legislative history.

A.

The Supreme Court has recognized claims of implied antitrust immunity for actions taken within a federally regulated industry. *See, e.g., Gordon v. New York Stock Exchange*, 422 U.S. 659 (1975); *United States v. National Association of Securities Dealers, Inc.*, 422 U.S. 694 (1975); *Pan American World Airways, Inc. v. United States*, 371 U.S. 296 (1963). Such implied repeals of the antitrust laws, however, are disfavored. *Gordon v. New York Stock Exchange*, 422 U.S. at 682. A claim of implied antitrust immunity can be upheld only if there is a "plain repugnancy between the antitrust and regulatory provisions." *United States v. Philadelphia National Bank*, 374 U.S. 321, 351 (1963) (footnote omitted); *see also Gordon v. New York Stock Exchange*, 422 U.S. at 682 (quoting *United States v. Philadelphia National Bank*). Phrased differently, the court must determine whether an implied repeal of the antitrust laws is " 'necessary to make the [regulatory scheme] work.' " *United States v. National Association of Securities Dealers, Inc.*, 422 U.S. at 734 (brackets in original) (quoting *Silver v. New York Stock Exchange*, 373 U.S. 341, 357 (1963)).

The Supreme Court was presented with a claim of implied antitrust immunity under the NHPRDA in *National Gerimedical Hospital & Gerontology Center v. Blue Cross*, 452 U.S. 378 (1981). In *National Gerimedical*, the defendant, Blue Cross, had refused to give the plaintiff hospital participant status because of the hospital's failure to obtain approval for its construction from the local HSA. At the time of construction, however, the State had no certificate of need procedure, and therefore HSA approval was not a requirement of state law. *Id.* at 389-90 & n. 15.

Holding that the facts did not present a clear repugnancy between the provisions of the NHPRDA and the antitrust laws, the Court rejected Blue Cross's claim of implied immunity. The Court found no evidence of Congressional intent to encourage spontaneous private enforcement of what amounted to an "advisory opinion" of an HSA. *Id.* at 391. Most important, the Court said that the lack of regulatory review and approval of Blue Cross's actions was "crucial" to its holding. *Id.* at 390. The opinion cited *Otter Tail Power Co. v. United States*, 410 U.S. 366 (1973), and *Silver v. New York Stock Exchange*, 373 U.S. 341 (1963), as cases in which a lack of regulatory review of the defendants' actions was an important factor in rejecting claims of implied antitrust immunity. 452 U.S. at 390. Accordingly, the Court stated:

> [O]ur holding does not foreclose future claims of antitrust immunity in other factual contexts. Although favoring a reversal in this case, the United States as *amicus curiae* asserts that "there are some activities that must, by implication, be immune from antitrust attack if HSAs and State Agencies are to exercise their authorized powers."

Id. at 393 n. 18.

The importance of regulatory review of the challenged activity was also stressed in *Gordon v. New York Stock Exchange*, 422 U.S. 659 (1975). In *Gordon*, the plaintiff alleged that certain of the defendant's practices, in particular the imposition of fixed commission rates, violated the antitrust laws. *Id.* at 661. The Exchange's claim of implied immunity, however, was upheld. The Court distinguished *Silver v. New York Stock Exchange*—a case in which the Exchange's claim of implied immunity had been rejected—on the grounds that the practices challenged in *Gordon* were within the regulatory power granted by the Securities Exchange Act of 1934 to the Securities and Exchange Commission, and the Commis-

sion had exercised that power. *Id.* at 683-85. The Court concluded that an implied repeal of the antitrust laws was "'necessary to make the Securities Exchange Act work,'" *id.* at 685 (quoting *Silver v. New York Stock Exchange*, 373 U.S. at 357), because application of the antitrust laws would "unduly interfere . . . with the operation of the Securities Exchange Act." *Id.* at 685-86.

A review of the facts in the instant case demonstrates that *Gordon*, rather than *National Gerimedical*, is controlling. In our case, the acquistion was reviewed and approved by the State Department of Human Resources. This approval was required by the North Carolina certificate of need law, *see* N.C. Gen. Stat. §§ 131-176(17)b., -178, which was enacted pursuant to the NHPRDA.

On the facts presented here, the NHPRDA and the certificate of need procedure it establishes are clearly repugnant to the antitrust laws. Congress determined that the problems of rising health care costs and uneven distribution of health care services were better remedied by a system of federal and state planning than by unbridled competition. Although Congress found that competition could be beneficial in certain areas of the health care industry, under the NHPRDA planning agencies are to promote competition only when the effects of competition would be consistent with state health care plans. Consequently, state health planning and development agencies are required to consider a number of factors, including competitive effects, in reviewing certificate of need applications. The antitrust laws, however, concern themselves solely with the protection of competition. *See Gordon v. New York Stock Exchange*, 422 U.S. at 689. To allow the application of the antitrust laws to strike down transactions approved by state agencies under a certificate of need program "would unduly interfere with the operation of the [NHPRDA]" and subject participants in the certificate of need process to "conflicting standards." *Id.* at 686, 689.

The Attorney General contends that this case presents no clear repugnancy between the NHPRDA and the antitrust laws because the NHPRDA did not require certificate of need review of the acquisition of Highland Hospital. Although at the time of the transaction North Carolina law required such review of all acquisitions of existing health care facilities, N.C. Gen. Stat. §§ 131-176(17)b., -178, the federal Act only requires review of such acquistions if the services or bed capacity of the acquired facility will be changed, or if notice of the acquisition is not timely filed, 42 U.S.C. § 300m-6(d)(1).[9] The record discloses no evidence that any of the conditions enumerated in the federal act occurred in the acquisition of Highland Hospital. However, it is evident from the provisions of the NHPRDA, its legislative history, and the applicable federal regulations that North Carolina's statutory decision to review all acquisitions of existing health care facilities was within the purposes and scope of the Act.

Although the NHPRDA is a federal act that imposes uniform national standards, Congress intended that the Act be implemented to fit individual state and community needs. S. Rep. No. 96-96, *supra*, at 51, 55, 1979 U.S. Code Cong. & Ad. News at 1356, 1360. This intent is manifest in the Act's delegation of planning and CON review power to state and local agencies. Consistent with this policy, Congressional committee reports are clear and explicit that the NHPRDA was not intended to preclude States from adopting more stringent or more com-

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[9] This provision was part of the Health Planning and Resources Development Amendments of 1979. *See* Pub. L. No. 96-79, § 117(d)(1), 93 Stat. 592, 617 (1979).

In 1981, North Carolina amended its law to cover only the acquisitions that are required by the NHPRDA to be covered. *See* N.C. Gen. Stat. § 131-176(17)(b)(j) (Supp. 1981). However, as discussed in note 6, *supra*, this amendment is inapplicable to the present case.

prehensive certificate of need programs than required by the Act. *Id.* at 43 & n. 2, 75, 1979 U.S. Code Cong. & Ad. News at 1348 & n.2, 1380; H.R. Conf. Rep. No. 96-420, 96th Cong., 1st Sess., *reprinted in* 1979 U.S. Code Cong. & Ad. News at 1422, 1453 (hereinafter cited as H.R. Conf. Rep. No. 96-420). States thus may require certificate of need review of "all acquisitions" of health care facilities. H.R. Conf. Rep. No. 96-420, *supra*, at 85, 1979 U.S. Code Cong. & Ad. News at 1453.[10] The Act in fact recognizes that different States may have differing certificate of need laws by providing additional funds for HSA's that incur extraordinary expenses due to differing certificate of need requirements. 42 U.S.C. § 300*l*-5(d)(2); S. Rep. No. 96-96, *supra*, at 70-71, 1979 U.S. Code Cong. & Ad. News at 1375-76.

Comments by the Secretary of Health, Education, and Welfare on regulations promulgated pursuant to the Health Planning and Resources Development Amendments of 1979, *see* 42 U.S.C. § 300m-2(a)(4)(B), provide additional authority for North Carolina's decision to subject all acquisitions of health care facilities to certificate of need review. The regulations concerning such review of hospital acquisitions track the statutory language. States are required to review only acquisitions that result in a change in services or bed capacity or for which timely notice is not filed. *See* 45 Fed. Reg. 69,747 (1980) (codified at 42 C.F.R. § 123.404(a)(5)(i) (1981)); 42 U.S.C. § 300m-6(a)(1). In a later comment, the Secretary said that they were intended to give States "substantial flexibility" in the implementation of their certificate of need programs. 45 Fed. Reg. at 69,740. Specifically, the Secretary said that States "are free to

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[10] Those activities that Congress determined should be exempt from certificate of need review are clearly specified in the NHPRDA. *See, e.g.*, 42 U.S.C. § 300m-6(e)(1) (granting a limited exemption for the acquisition of major medical equipment not owned by or located in a health care facility); *see also id.* § 300m-6(b)(1).

exceed the minimum requirements" of the certificate of need regulations except when prohibited, which this one is not. *Id.* at 69,740, 69,746. And, in commenting on the proposed regulations, which were later adopted, with respect to "acquisitions of existing facilities," the precise point at issue in this case, the Secretary stated:

> The Secretary notes that States may, if they choose, cover additional (or all) acquisitions of health care facilities, in which case, because a regular certificate of need would be required, a notice of intent would not be required. States might consider extending their coverages to all acquisitions if they believe that acquisitions may be likely to lead to higher health care costs for consumers and third party payors. 45 Fed. Reg. 20,028 (1980).

Subjecting mere acquisitions of health care facilities to certificate of need review can further important policies of the NHPRDA. In this case, the North Carolina Department of Human Resources found that, if Highland Hospital had continued charging its pre-acquisition rates, it soon would have been operating at a deficit. The rates proposed by PIA, however, would "have the least possible impact on the [hospital's] costs and charges" while at the same time assuring "immediate and long-term financial feasibility." This furthers the policy of "increasing the accessibility . . ., continuity, and quality of health services provided." 42 U.S.C. § 300*l*-2(a)(2). The department also found that the proposed financing package assured that "minimal financing costs will be incorporated in any future rate increases." This furthers the policy of "restraining increases in the cost of providing . . . health services." *Id.* § 300*l*-2(a)(3).[11] In requiring review of the acquisi-

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[11] In commenting on the proposed regulations, the Secretary of Health, Education, and Welfare recognized that mere acquisitions could affect health care costs. 45 Fed. Reg. 20,028 (1980).

tion of Highland Hospital, therefore, North Carolina was acting within the scope and purposes of the NHPRDA. Thus, the fact that the federal statute did not require certificate of need review of the acquisition does not affect our holding that the facts of this case present a clear repugnancy between the NHPRDA and the antitrust laws.

B.

Although implied antitrust immunity on the facts presented here is evident from the NHPRDA's regulatory structure alone, the legislative history of the Act provides direct evidence of Congressional intent to exempt from the antitrust laws actions that are subjected to certificate of need review. A statement by Representative Paul Rogers, a sponsor of both the original 1974 Act and the 1979 amendments, makes this intent clear:

> Although . . . [the NHPRDA] contains no specific exemption from the antitrust laws, an analysis of the activities required of HSA's and providers indicates that Congress sanctioned actions which might otherwise be in violation of our antitrust laws. The intent of Congress was that HSA's and providers who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to the antitrust laws. If they were, [the NHPRDA] simply could not be implemented.

124 Cong. Rec. H11,963 (daily ed. Oct. 10, 1978).[12] Further evidence of Congressional intent to immunize conduct approved under a state certificate of need program is provided in a report by the House Committee on Interstate and Foreign Commerce:

> While the application of the antitrust laws to promote competition is and should be the general

[12] The Supreme Court quoted this statement in part in *National Gerimedical Hospital & Gerontology Center v. Blue Cross*, 452 U.S. at 393 n. 18.

> rule, the committee believes that a practical and realistic analysis of the health care industry argues for exceptions to the rule. . . . Congress *required* health planning agencies to carry out specific functions and established a financial penalty for States which failed to comply with the requirements. Those statutory requirements and penalty indicate that Congress did not expect the antitrust laws to be applied to agency actions, which might otherwise be in violation of the antitrust laws, if those agency actions were necessary to carry out the prescribed functions. On the other hand, however, agency acts which are not necessary to carry out such functions or which are outside the scope of title XV are not authorized and therefore not immue from the application of the antitrust laws.

H.R. Rep. No. 96-190, *supra*, at 54-55 (emphasis in original).

The NHPRDA requires state planning agencies to administer a certificate of need program. Therefore, the process of reviewing and approving business transactions that are within the contemplation of the federal certificate of need law is within the scope of the Act and entitled to antitrust immunity. As discussed above, North Carolina's review and approval of the Highland Hospital's acquisition was within the scope of the NHPRDA's certificate of need program, and thus we think Congress intended to immunize the transaction from antitrust liability.

IV.

We cannot summarize the case better than by quoting the Senate Report in 1979, U.S. Code Cong. & Ad. News, where the committee explained the meaning of the statute and analyzed some of its results on pages 1356 and 1357:

> When we say "improve decisions,["] we mean several things, things that are the very essence of what the health planning program is about:

We mean a local decision structure in which every one has an opportunity to participate—indeed it is dependent upon the effective participation of citizen volunteers;

We mean decisions that are made within the framework of a community-wide and community-developed long-range plan for sensible investment decisions;

We mean a plan that recognizes real constraints on resources—a reality-based plan that will not condone every added expenditure desired by every hospital and every physician;

We mean a program which keeps most regulatory powers needed to enforce the plan in the hands of State government, not the Federal Government.

One might then ask: What has that improved decisionmaking process accomplished? Although the health planning agencies were established and "conditionally designated" by the HEW Secretary less than 3 years ago, it is now becoming possible to see the results of their efforts.

A recent survey of the planning agencies' performance in reviewing new capital investment projects covered the 2-year period from the summer of 1976 to the summer of 1978. The first report of that survey, which analyzed data on the first 139 health systems agencies surveyed, provides some interesting statistics:

These 139 HSA's, which cover about 60 percent of the population of the country, reviewed more than $7 billion in proposed capital investments, in spite of the fact that many of these agencies did not begin such review until 1977.

Of that $7 billion, one quarter was deemed unnecessary and was not allowed to go forward. In

other words, more than $1.8 of unneeded capital investment expenditures was prevented.

Pitting the cost of these HSA's and the relevant State agencies against the result, we find that for each dollar spent on health planning, $8 in proposed capital investments were denied—an impressive rate of return indeed.

If we further consider the operational costs that will not now be incurred in conjunction with $1.8 billion of unneeded capital projects, the savings are magnified many times again. For we know that annual operating costs approximate 50 percent of the capital costs.

It should be noted that these savings have occurred in the absence of any supportable claim that the quality of health care has suffered in any way.

Thus, the legislative history clearly indicates that the Congressional purpose of the enactment of the statute was a national plan of health care, and the carrying out of this national plan has been shown to be successful. The permissible state regulation of the acquisition of health care facilities under the national health plan is inconsistent with its regulation under the antitrust laws. We think "antitrust immunity is 'necessary to make the [NHPRDA] work' ". *National Gerimedical*, at p. 393, n.18.

In conclusion, we hold that the NHPRDA provides implied immunity from the federal antitrust laws for the defendants' acquisition [13] of Highland Hospital. Such

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[13] The dissent argues and emphasizes as a reason for its position that "Congress cannot have intended to immunize from antitrust scrutiny the *post-acquisition activities* of health care providers, simply because the *acquisitions themselves* must pass CON review." (Italics from the dissent) This argument reads too much into our opinion. It is only the acquisition that is immunized, not post-acquisition activities, which, of course, are not immune. For a good

immunity is evident from both the regulatory structure of the Act and its legislative history. The federal law claims must therefore be dismissed, and under *United Mine Workers v. Gibbs*, 383 U.S. 715, 726 (1966), the pendent state law claims were properly dismissed also.

AFFIRMED.

RUSSELL, Circuit Judge, dissenting:

The majority finds that immunity from the federal antitrust laws may be, and here is, implicit in a statute, the National Health Planning and Resources Development Act of 1974 (hereafter NHPRDA), 42 U.S.C. §§ 300k *et seq.*, *amended by* 42 U.S.C. § 300k-2. Upon this basis the majority upholds the district court. I find that a grant of antitrust immunity may not be inferred from the NHPRDA absent an express provision therefor. Since the NHPRDA contains no such provision, I cannot agree with the majority.

The district court found as an alternative basis for its grant of summary judgment that the defendants were immunized from liability by the state action doctrine, as expressed in *Parker v. Brown*, 317 U.S. 341 (1943). The majority did not reach this issue; neither do I.

My reasons for dissenting here, briefly: Implied repeals in the antitrust field have been strongly disfavored for over forty years, ever since *United States v. Borden Co.*, 308 U.S. 188, 198, 60 S.Ct. 182, 84 L.Ed. 181 (1939). This is not to say that no implied repeal may ever be found; the Supreme Court has recognized that "there are some activities that must, by implication, be immune from antitrust attack if HSA's and state agencies are to exercise their authorized powers," *National*

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current discussion of the requirement of anticompetitive conduct, not mere monopoly, in the context present here, see *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263 (2d Cir. 1979).

Geremedical Hospital and Gerontology Center v. Blue Cross of Kansas City, 452 U.S. at 393 n. 18. However, for immunity from federal antitrust laws to be implied by a statute, there must be a "plain repugnancy" between the requirements of the statute and those of the antitrust laws, *United States v. Philadelphia National Bank*, 374 U.S. at 351, and even then, the antitrust laws may be repealed only to the "minimum extent necessary" to obviate the clear repugnancy, *Silver v. New York Stock Exchange*, 373 U.S. at 357.

As a general rule, the Supreme Court has recognized a statute as repealing the antitrust laws by implication *only* where the statute provided *ongoing* government supervision as a substitute for antitrust scrutiny. *Cf.*, *United States v. Philadelphia National Bank*, 374 U.S. at 351-52 (no ongoing supervision, so no exemption), with *Gordon v. New York Stock Exchange*, 422 U.S. at 89-90 n.14, (SEC had ongoing supervision, so exemption found).

The NHPRDA, as implemented by North Carolina's enabling legislation,[1] does give the state agency, the HSA, the power to scrutinize certain acquisitions and expenditures through "certificate of need" (hereafter CON) review. In exercising such power, the state agency provides for public comment and a hearing, and it requires that, in its decision, the agency must support its conclusions by appropriate findings of fact. The agency's decisions are subject to judicial review. In its consideration of an acquisition or addition, the agency is expected to approve only allocations to provide services "for which competition does not or will not appropriately allocate supply." [2] For those health services "for which competition appropriately allocates supply, . . . states should give priority . . . to actions which would strengthen the

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[1] N.C. Gen. Stat. §§ 131-175 *et seq.* (1981).

[2] 42 U.S.C. § 300k-2(b)(2).

effect of competition on the supply of such services." [3] To this extent only is competition considered. Specifically, there is no consideration by the state agency of costs and charges after acquisition,[4] although the federal statute authorizes such review.[5] In short, for the reasons stated, North Carolina's CON statute leaves entities like appellant PIA entirely free to indulge in such post-acquisition activities as price-fixing—activities which Congress intended to curb through the federal antitrust laws.

Just what the result can be is illustrated strikingly by what has occurred here. The acquiring hospital expects, after acquisition, to raise rates at the acquired institution. It is obvious from this review of both the NHPRDA and the state act that CON review is not incompatible with federal antitrust laws, nor is the NHPRDA so comprehensive a statute that it obviates the need for antitrust scrutiny. Here, then, there is no clear repugnancy.

The majority reaches its contrary decision after drawing what I view to be an unwarranted inference that the legislative history of the NHPRDA shows Congressional intent to provide antitrust exemption, and after a consideration of only two cases.

The two cases relied upon by the majority are *National Geremedical Hospital and Gerontology Center v. Blue Cross of Kansas City* and *Gordon v. New York Stock Exchange*. The former involves precisely the question of whether the NHPRDA implicitly repealed the antitrust laws for actions arising under it; the latter, whether the Securities Exchange Act of 1934 had repealed the antitrust laws by implication, for fixed rates

[3] 42 U.S.C. § 300k-2(b)(3).

[4] N.C. Gen. Stat. § 131-177.

[5] 42 U.S.C. § 300m-5(a).

required by the New York Stock Exchange. Thus on the facts alone, *National Geremedical* would seem to be a precedent with more authority in this case. Nonetheless, the majority found *Gordon* controlling, apparently only because the *Gordon* court had found an implied repeal of the antitrust laws essential to make the statute in question, the 1934 Securities Exchange Act, work—whereas the *National Geremedical* court had rejected the claim of implied immunity because the facts of the case showed no "plain repugnancy" between the NHPRDA and federal antitrust laws.

Admittedly, in *National Geremedical* the state had implemented no CON requirement. Plaintiff hospital, whose failure to obtain CON approval was the basis for Blue Cross's refusal to grant it participant status, had thus been under no obligation to obtain such approval. When plaintiff hospital alleged that Blue Cross was violating the antitrust laws by refusing to grant the hospital participant status, Blue Cross responded by claiming antitrust immunity under the NHPRDA. The court did state, at 393 n.18, that its holding was not to preclude other allegations of antitrust immunity. It also said that a "crucial" factor, *id.* at 390, in its holding was the absence of regulatory (CON) review of Blue Cross's decision. However, the court said neither that its decision would have been different if there had been mandatory CON review, nor that the absence of CON review was the only, or even the pivotal, reason for its decision.

Appellant PIA's argument, in light of the above discussion, does not seem to me to be sustainable on the ground of either precedent or legislative history. Congress's finding that competition is an inadequate safeguard against abuses in the health care industry was based upon the inefficacy of competition in keeping down medical costs. Removing the possibility of antitrust scrutiny would simply exacerbate that problem, by allowing unchecked rate-setting. Congress has shown its

grave concern over the spiralling costs of health care. The federal antitrust laws are a weapon created by Congress to prevent unfair competition and monopoly from aggravating the problem of high costs for the consumer. Congress cannot have intended to immunize from antitrust scrutiny the *post-acquisition activities* of health care providers, simply because the *acquisitions themselves* must pass CON review. CON review, the NHPRDA, and the federal antitrust laws may not have identical, overlapping goals, but they do have the consistent goal of insuring that health care costs are not unnecessarily and artificially inflated. State regulation of acquisitions and expenditures in areas not responsive to competition alone is not, as the majority seems to contend, irreconcileable with protecting competition where it does exist within the industry. There is no need to suppress the federal antitrust laws in order to make fully effective the NHPRDA and North Carolina's CON review statute. Indeed, there is no justification for finding such an implied repeal. I believe that PIA's acquisition of Highland may claim no immunity from federal antitrust scrutiny. I dissent.

APPENDIX E

THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT

§ 300k-2. National health priorities; strengthening competition in supply of services

(a) The Congress finds that the following deserve priority consideration in the formulation of national health planning goals and in the development and operation of Federal, State, and area health planning and resources development programs:

(1) The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas.

(2) The development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services).

(3) The development of medical group practices especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care.

(4) The training and increased utilization of physician assistants, especially nurse clinicians.

(5) The development of multi-institutional arrangements for the sharing of support services necessary to all health institutions.

(6) The promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of

Professional Standards Review Organizations under Part B of Title XI of the Social Security Act.

(7) The development by health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis.

(8) The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.

(9) The adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions and the development and use of cost saving technology.

(10) The development of effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health services.

(11) The promotion of an effective energy conservation and fuel efficiency program for health service institutions to reduce the rate of growth of demand for energy.

(12) The identification and discontinuance of duplicative or unneeded services and facilities.

(13) The adoption of policies which will (A) contain the rapidly rising costs of health care delivery, (B) insure more appropriate use of health care services, and (C) promote greater efficiency in the health care delivery system.

(14) The elimination of inappropriate placement in institutions of persons with mental health problems and the improvement of the quality of care

provided those with mental health problems for whom institutional care is appropriate.

(15) Assurance of access to community mental health centers and other mental health care providers for needed mental health services to emphasize the provision of outpatient as a preferable alternative to inpatient mental health services.

(16) The promotion of those health services which are provided in a manner cognizant of the emotional and psychological components of the prevention and treatment of illness and the maintenance of health.

(17) The strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve, in accordance with subsection (b) of this section, to advance the purposes of quality assurance, cost effectiveness, and access.

(b) (1) The Congress finds that the effect of competition on decisions of providers respecting the supply of health services and facilities is diminished. The primary source of the lessening of such effect is the prevailing methods of paying for health services by public and private health insurers, particularly for inpatient health services and other institutional health services. As a result, there is duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services.

(2) For health services, such as inpatient health services and other institutional health services, for which competition does not or will not appropriately allocate supply consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the exercise of their functions under this subchapter take actions (where appropriate to advance the purpose of quality

assurance, cost effectiveness, and access and the other purposes of this subchapter) to allocate the supply of such services.

(3) For the health services for which competition appropriately allocates supply consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the performance of their functions under this subchapter give priority (where appropriate to advance the purposes of quality assurance, cost effectiveness and access) to actions which would strengthen the effect of competition on the supply of such services.

§ 300m-6. Certificate of need program

Determination of need for equipment and services; criteria for review of application; timetable for delivery of equipment and services; withdrawal of certificate; maximum amount of capital expenditures; review of changes

(a) The certificate of need program required by section 300m-2(a)(4)(B) of this title shall, in accordance with this section, provide for the following:

(1) Review and determination of need under such program for—

(A) major medical equipment and institutional health services, and

(B) capital expenditures,

shall be made before the time such equipment is acquired, such services are offered, substantial expenditures are undertaken in preparation for such offering, or capital expenditures are obligated.

(2) The acquisition and offering of only such equipment and services as may be found by the State Agency to be needed; and the obligation of only those

capital expenditures found to be needed by the State Agency. Except as otherwise authorized by this section, review under the program of an application for a certificate of need may not be made subject to any criterion and the issuance of a certificate of need may not be made subject to any condition unless the criterion or condition directly relates to—

(A) criteria prescribed by section 300n-1(c) of this title,

(B) criteria prescribed by regulations of the Secretary promulgated under section 300n-1(a) of this title before October 4, 1979, or

(C) criteria prescribed by regulation by the State Agency in accordance with an authorization prescribed by State law.

The Secretary may not require a State to include in its program any criterion in addition to criteria described in subparagraphs (A) and (B).

(3) An application for a certificate of need for an institutional health service, medical equipment, or a capital expenditure shall specify the time the applicant will require to make such service or equipment available or to obligate such expenditure and a timetable for making such service or equipment available or obligating such expenditure. After the issuance of a certificate of need, the State Agency shall periodically review the progress of the holder of the certificate in meeting the timetable specified in the approved application for the certificate. If on the basis of such a review the State Agency determines that the holder of a certificate is not meeting such timetable and is not making a good faith effort to meet it, the State Agency may, after considering any recommendation made by the health systems

agency which received a report from the State Agency on such review, withdraw the certificate.

(4) In issuing a certificate of need, the State shall specify in the certificate the maximum amount of capital expenditures which may be obligated under such certificate. The program shall, in accordance with regulations promulgated by the Secretary, prescribe the extent to which a project authorized by a certificate of need shall be subject to further review if the amount of capital expenditures obligated or expected to be obligated for the project exceed the maximum specified in the certificate of need.

(5) The program shall provide that (A) the requirements of section 300n-1 of this title shall apply to proceedings under the program, and (B) each decision to issue a certificate of need (i) may only be issued by the State Agency, and (ii) shall, except in emergency circumstances that pose a threat to public health, be consistent with the State health plan in effect for such State under section 300m-3(c) of this title.

Exemption from certificate; conditions; sale, lease, or acquisition of facility or equipment; subsidiary health maintenance organization or ambulatory health care facility; approval of application

(b)(1) Under the program a State shall not require a certificate of need for the offering of an inpatient institutional health service or the acquisition of major medical equipment for the provision of an inpatient institutional health service or the obligation of a capital expenditure for the provision of an inpatient institutional health service by—

(A) a health maintenance organization or a combination of health maintenance organizations if (i)

the facility in which the service will be provided is or will be geographically located so that the service will be reasonably accessible to individuals enrolled in such organization or organizations, and (ii) at least 75 percent of the patients who can reasonably be expected to receive the institutional health service will be individuals enrolled with such organization or organizations in the combination;

(B) a health care facility if (i) the facility primarily provides or will provide inpatient health services, (ii) the facility is or will be controlled, directly or indirectly, by a health maintenance organization or a combination of health maintenance organizations, (iii) the facility is or will be geographically located so that the service will be reasonably accessible to individuals enrolled in such organization or organizations, and (iv) at least 75 percent of the patients who can reasonably be expected to receive the institutional health service will be individuals enrolled with such organization or organizations in the combination, or

(C) a health care facility (or portion thereof) if (i) the facility is or will be leased by a health organization or combination of health maintenance organizations and on the date the application is submitted under paragraph (2) at least fifteen years remain in the term of the lease, (ii) the facility is or will be geographically located so that the service will be reasonably accessible to individuals enrolled in such organization or organizations, and (iii) at least 75 percent of the patients who can reasonably be expected to receive the institutional health service will be individuals enrolled with such organization,

if, with respect to such offering, acquisition, or obligation, the State Agency has, upon application under paragraph (2), granted an exemption from such requirement to the organization, combination of organizations, or facility.

(2) A health maintenance organization, combination of health maintenance organizations, or health care facility shall not be exempt under paragraph (1) from obtaining a certificate of need before offering an institutional health service, acquiring major medical equipment, or obligating capital expenditures unless—

(A) it has submitted, at such time and in such form and manner as the State Agency shall prescribe, an application for such exemption,

(B) the application contains such information respecting the organization, combination, or facility and the proposed offering, acquisition, or obligation as the State Agency may require to determine if the organization or combination meets the requirements of paragraph (1) or the facility meets or will meet such requirements, and

(C) the State Agency approves such application.

In the case of a proposed health care facility (or portion thereof) which has not begun to provide institutional health services on the date of an application is submitted under this paragraph with respect to such facility (or portion), the facility (or portion) shall meet the applicable requirements of paragraph (1) when the facility first provides such services. The State Agency shall approve an application submitted under this paragraph if it determines that the applicable requirements of paragraph (1) are met.

(3) Notwithstanding subsection (d) of this section, a health care facility (or any part thereof) or medical equipment with respect to which an exemption was granted under paragraph (1) may not be sold or leased and a controlling interest in such facility or equipment or in a lease of such facility or equipment may not be acquired and a health care facility described in subparagraph (C) of paragraph (1) which was granted an exemption under paragraph (1) may not be used by any

person other than the lessee described in such subparagraph unless—

(A) the State Agency issues a certificate of need approving the sale, lease, acquisition, or use, or

(B) the State Agency determines, upon application, that the entity to which the facility or equipment is proposed to be sold or leased, which intends to acquire the controlling interest in or use the facility is (i) a health maintenance organization or a combination of health maintenance organizations which meets the requirements of clause (i) of subparagraph (A) of paragraph (1) and with respect to such facility or equipment, the entity meets the requirements of clauses (ii) and (iii) of such subparagraph (A), or (ii) a health care facility which meets the requirements of clauses (i), (ii), and (iii) of subparagraph (B) of paragraph (1) and with respect to its patients meets the requirements of clause (iv) of such subparagraph.

(4) In the case of a health maintenance organization or an ambulatory care facility or health care facility which ambulatory or health care facility is controlled, directly or indirectly, by a health maintenance organization or a combination of health maintenance organizations, a State may under the program apply its certificate of need requirements only to the offering of inpatient institutional health services, the acquisition of major medical equipment, and the obligation of capital expenditures for the offering of inpatient institutional health services and then only to the extent that such offering, acquisition, or obligation is not exempt under paragraph (1).

(5) Notwithstanding section 300n-1(c) of this title, if a health maintenance organization or a health care facility which is controlled, directly or indirectly, by a health maintenance organization apply for a certificate of need, such application shall be approved by the State

Agency if the State Agency finds (in accordance with criteria prescribed by the Secretary by regulation) that—

(A) approval of such application is required to meet the needs of the members of the health maintenance organization and of the new members which such organization can reasonably be expected to enroll, and

(B) the health maintenance organization is unable to provide, through services or facilities which can reasonably be expected to be available to the organization, its institutional health services in a reasonable and cost-effective manner which is consistent with the basic method of operation of the organization and which makes such services available on a long-term basis through physicians and other health professionals associated with it.

Except as provided in paragraph (1) and notwithstanding subsection (d) of this section, a health care facility (or any part thereof) or medical equipment with respect to which a certificate of need was issued under this subsection may not be sold or leased and a controlling interest in such facility or equipment or in a lease of such facility or equipment may not be acquired unless the State Agency issues a certificate of need approving the sale, acquisition, or lease.

* * * *

Acquisition of existing facility

(d) (1) Under the program a certificate of need shall, except as provided in subsection (b) of this section, be required for the obligation of a capital expenditure to acquire (either by purchase or under lease or comparable arrangement) an existing health care facility if—

(A) the notice required by paragraph (2) is not filed in accordance with that paragraph with respect to such acquisition, or

(B) the State Agency finds, within thirty days after the date it receives a notice in accordance with paragraph (2) with respect to such acquisition, that the services or bed capacity of the facility will be changed in being acquired.

(2) Before any person enters into a contractual arrangement to acquire an existing health care facility which arrangement will require the obligation of a capital expenditure, such person shall notify the State Agency of the State in which such facility is located of such person's intent to acquire such facility and of the services to be offered in the facility and its bed capacity. Such notice shall be made in writing and shall be made at least thirty days before contractual arrangements are entered into to acquire the facility with respect to which the notice is given.

Acquisition of major medical equipment not owned by or located in health care facility

(e) (1) (A) Except as provided in subsection (b) of this section and subparagraph (B), under the program a certificate of need shall not be required for the acquisition of major medical equipment which will not be owned by or located in a health care facility unless—

(i) the notice required by paragraph (2) is not filed in accordance with that paragraph with respect to such acquisition, or

(ii) the State Agency finds, within thirty days after the date it receives a notice in accordance with paragraph (2) with respect to such acquisition, that the equipment will be used to provide services for inpatients of a hospital.

(B) The certificate of need program of a State may include a requirement for a certificate of need for an acquisition of major medical equipment which requirement is in addition to the requirement for a certificate

of need established by subparagraph (A), except that after September 30, 1982, the certificate of need program of a State may not be changed to include any such additional requirement.

(2) Before any person enters into a contractural arrangement to acquire major medical equipment which will not be owned by or located in a health care facility, such person shall notify the State Agency of the State in which such equipment will be located of such person's intent to acquire such equipment and of the use that will be made of the equipment. Such notice shall be made in writing and shall be made at least thirty days before contractual arrangements are entered into to acquire the equipment with respect to which the notice is given.

(3) For purposes of this subsection, donations and leases of major medical equipment shall be considered acquisitions of such equipment, and an acquisition of medical equipment through a transfer of it for less than fair market value shall be considered an acquisition of major medical equipment if its fair market value is at least $150,000.

§ 300n-1. Procedures and criteria for review of proposed health system changes

* * * *

Minimum criteria

(c) Criteria required by subsection (a) of this section for health systems agency, State Agency, and Statewide Health Coordinating Council review shall include consideration of at least the following:

(1) The relationship of the health services being reviewed to the applicable HSP, AIP, and State health plan.

(2) The relationship of services reviewed to the long-range development plan (if any) of the person providing or proposing such services.

(3) The need that the population served or to be served by such services has for such services.

(4) The availability of alternatives, less costly, or more effective methods of providing such services.

(5) The relationship of services reviewed to the existing health care system of the area in which such services are provided or proposed to be provided.

(6) In the case of health services proposed to be provided—

(A) the availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of such services,

(B) the effect of the means proposed for the delivery of such services on the clinical needs of health professional training programs in the area in which such services are to be provided,

(C) if such services are to be available in a limited number of facilities, the extent to which the health professions schools in the area will have access to the services for training purposes,

(D) the availability of alternative uses of such resources for the provision of other health services, and

(E) the extent to which such proposed services will be accessible to all the residents of the area to be served by such services.

(7) The special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas. Such entities may include medical and other health

professions schools, multidisciplinary clinics, specialty centers, and such other entities as the Secretary may by regulation prescribe.

(8) The special needs and circumstances of health maintenance organizations.

(9) In the case of a construction project—

(A) the costs and methods of the proposed construction, including the costs and methods of energy provision, and

(B) the probable impact of the construction project reviewed on the costs of providing health services by the person proposing such construction project and on the costs and charges to the public of providing health services by other persons.

(10) The special circumstances of health service institutions and the need for conserving energy.

(11) In accordance with section 300k-2(b) of this title, the factors which affect the effect of competition on the supply of the health services being reviewed.

(12) Improvements or innovations in the financing and delivery of health services which foster competition, in accordance with section 300k-2(b) of this title, and serve to promote quality assurance and cost effectiveness.

(13) In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities similar to those proposed.

(14) In the case of existing services or facilities, the quality of care provided by such services or facilities in the past.

The criteria established by any health systems agency, State Agency, or Statewide Health Coordinating Council under paragraph (8) shall be consistent with the standards and procedures established by the Secretary under section 300e-5(c) of this title.

NORTH CAROLINA

CERTIFICATE OF NEED LAW.

§ 131-175. **Findings of fact.**—The General Assembly of North Carolina makes the following findings:

(1) That, because of the manner in which health care is financed, the forces of free market competition are largely absent and that government regulation is therefore necessary to control the cost, utilization, and distribution of health services.

(2) That the continuously increasing cost of health care services threatens the health and welfare of the citizens of this State in that citizens need assurance of economical, and readily available health care.

(3) That the current system of planning for health care facilities and equipment has led to the proliferation of new inpatient acute care facilities and medical equipment beyond the need of many localities in this State and an inadequate supply of health personnel and of resources for long term, intermediate, and ambulatory care in many localities.

(4) That this trend of proliferation of unnecessary health care facilities and equipment results in costly duplication and underuse of facilities, with the availability of excess capacity leading to unnecessary use of expensive resources and overutilization of acute care hospital services by physicians.

(5) That a certificate of need law is required by P.L. 93-641 as a condition for receipt of federal funds. If these funds were withdrawn the State of North Carolina would lose in excess of fifty-five million dollars ($55,000,000).

(6) That excess capacity of health facilities places an enormous economic burden on the public who pay for the construction and operation of these facilities as patients, health insurance subscribers, health plan contributors, and taxpayers.

(7) That the general welfare and protection of lives, health, and property of the people of this State require that new institutional health services to be offered within this State be subject to review and evaluation as to type, level, quality of care, feasibiilty, and other criteria as determined by provisions of this Article or by the North Carolina Department of Human Resources pursuant to provisions of this Article prior to such services being offered or developed in order that only appropriate and needed institutional health services are made available in the area to be served. (1977, 2nd Sess., c. 1182, s. 2).

§ 131-181. **Review criteria.**—(a) The Department shall promulgate rules implementing criteria outlined in this subsection to determine whether an applicant is to be issued a certificate for the proposed project. Criteria so implemented are to be consistent with federal law and regulations and shall cover:

(1) The relationship of the proposed project to the State Medical Facilities Plan, the State Health Plan, and the State Medical Health Plan.

(2) The relationship of services reviewed to the long-range development plan of the persons providing or proposing such services.

(3) The need that the population served or to be served by such services has for such services.

(4) The availability of less costly or more effective alternative methods of providing such services.

(5) The immediate and long-term financial feasibility of the proposal, as well as the probable impact of the proposal on the costs of and charges for providing health services.

(6) The relationship of the services proposed to be provided to the existing health care system of the area in which such services are proposed to be provided.

(7) The availability of resources, including health manpower, management personnel, and funds for capital and operating needs, for the provision of the services proposed to be provided and the availability of alternative uses of such resources for the provision of other health services.

(8) The relationship, including the organizational relationship, of the health services proposed to be provided to ancillary or support services.

(9) Special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas. Such entities may include medical and other health professions schools, multidisciplinary clinics and specialty centers.

(10) The special needs and circumstances of health maintenance organizations for which assistance may be provided under Title XIII of the Public Health Service Act. Such needs and circumstances include the needs of and costs to mem-

bers and projected members of the health maintenance organization in obtaining health services and the potential for a reduction in the use of inpatient care in the community through an extension of preventive health services and the provision of more systematic and comprehensive health services. The consideration of a new institutional health service proposed by a health maintenance organization shall also address the availability and cost of obtaining the proposed new institutional health service from the existing providers in the area that are not health maintenance organizations.

(11) The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

(12) In the case of a construction project, the costs and methods of the proposed construction, including the costs and methods of energy provision, and the probable impact of the construction project reviewed on the costs of providing health services by the person proposing the construction project.

(13) The need that the medically underserved portion of the population, especially those people located in rural or economically depressed areas, has for such services, and the extent to which the project under review proposes to meet that need.

(b) Criteria adopted for reviews in accordance with subsection (a) of this section may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. (1977, 2nd Sess., c. 1182, s. 2)